

The Efficacy of Narrative Reformulation of Depression in Cognitive Analytic Therapy; a Deconstruction Trial

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By Clair Stockton

Thesis submitted to the University of Sheffield for the degree of
Doctor of Clinical Psychology
July 2012



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Declaration

This work has not been submitted to any other institution or for any other qualification.

Structure

The literature review and research report contained in this thesis have been prepared in accordance with the guidelines for the structure of articles specified by the British Journal of Clinical Psychology.

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Thesis Abstract

Literature Review. Therapeutic letters (TLs) are used to augment psychotherapeutic interventions across a range of modalities. This review assimilates and critically evaluates the TL research. It considers their impact on (1) the client, (2) the clinician, and (3) therapeutic processes. Findings suggest TLs may be helpful tools, enhancing therapeutic connections, extending the work of therapy and assisting client management of endings. They may also assist clinicians to manage boundaries effectively, and have utility as professional educational tools. Further research is recommended regarding TLs impact on client outcomes and potential negative effects, their use in clinical practice and impact on therapeutic processes.

Empirical Research. This study seeks to investigate (1) the efficacy of narrative reformulation (NR) in Cognitive Analytic Therapy (CAT) for depression, (2) the impact of NR on the therapeutic alliance and perceived helpfulness of therapy and (3) provide initial practice-based evidence of the effectiveness of brief CAT. A randomised and controlled deconstruction trial compared standard CAT with CAT without NR. (Data from both arms examined overall effectiveness). Measures were administered at screening, treatment sessions and follow-up (Patient Health Questionnaire, Working Alliance Inventory, Helpful Aspects of Therapy). NR did not enhance the efficacy of CAT, the therapeutic alliance or helpfulness of therapy. Highly significant reductions in depression were achieved (pre-post) in the full sample. NR does not appear crucial to the efficacy of CAT for depression. Brief CAT appears an effective treatment for depression. Further research regarding the clinical effectiveness and efficacy of CAT is recommended.

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Exploring the impact of therapeutic letter writing: A review of the empirical literature

Abstract

Therapeutic letters (TLs) are regularly used to augment psychotherapeutic interventions across a range of modalities (Moules, 2002), providing an additional dimension to therapy (Pyle, 2009). Whilst numerous anecdotal reports testify to TLs usefulness (e.g. Bennett, 1994; Alexander, Shilts, Liscio & Rambo; 2008), sound empirical research is scarce. This review aims to assimilate and critically evaluate the research regarding TLs, presenting a broad assessment of the current evidence. Nineteen journal articles published prior to April 2012 in PsychINFO, MEDLINE, Web of Knowledge, the Cochrane Library, and from the authors' knowledge of the area met the inclusion criteria. Identified research was primarily qualitative (n= 13). This review organizes the literature on the impact of TLs on (1) the client, (2) the clinician, and (3) therapeutic processes. Findings suggest TLs may be helpful tools in enhancing therapeutic connections, extending the work of therapy and assisting in client management of endings. Additionally, TLs may assist clinicians to manage boundaries effectively, and have utility as professional educational tools. Further research is required regarding TLs impact on client outcomes and potential negative effects, their use in clinical practice and impact on therapeutic processes.

Introduction

Therapeutic letters (TLs) are commonly employed across a range of psychotherapeutic modalities, as an adjunct to therapeutic interventions. These clinician-authored documents differ from administrative or inter-professional letters in terms of their intent, content and contextual position within therapy (Moules, 2002). TLs seek to enhance positive elements of the therapeutic process by summarising, validating/expanding session content, sharing clinical thinking, engaging clients and promoting hope (Alexander et al., 2008). TLs are used in narrative approaches (Rombach, 2003), cognitive analytic therapy (CAT; Ryle & Kerr, 2002), family therapy (Marner, 1995), nursing (Moules, 2009), counselling (Kindsvatter, Nelson & Desmond, 2009) and psychotherapy (Ingrassia, 2003). TLs have been used with both physical and mental health problems in individual, couples and family work across the age ranges (Bell, Moules & Wright, 2009). TLs consume valuable in and out of session time (Howlett & Guthrie, 2001) and so their effectiveness requires thorough investigation. Identifying tools that augment treatment effectiveness has obvious clinical utility (Llewelyn & Hardy, 2001). Whilst numerous anecdotal reports champion the perceived usefulness of TLs (e.g. Marner, 1995; Hoffman, Hinkle & Kress, 2010), sound empirical research is scarce. The quality of both quantitative and qualitative TL data also requires careful consideration.

The primary aims of this review are:

1. To assimilate the current empirical research on TL writing across a range of psychotherapeutic modalities.

2. To present and critically evaluate research concerned with the applications of TLs across therapeutic modalities.
3. To provide a broad assessment of the quality of current evidence.

TL evidence is organised into three broad categories, addressing the impact of TLs on (1) the client, (2) the clinician, and (3) the therapeutic process.

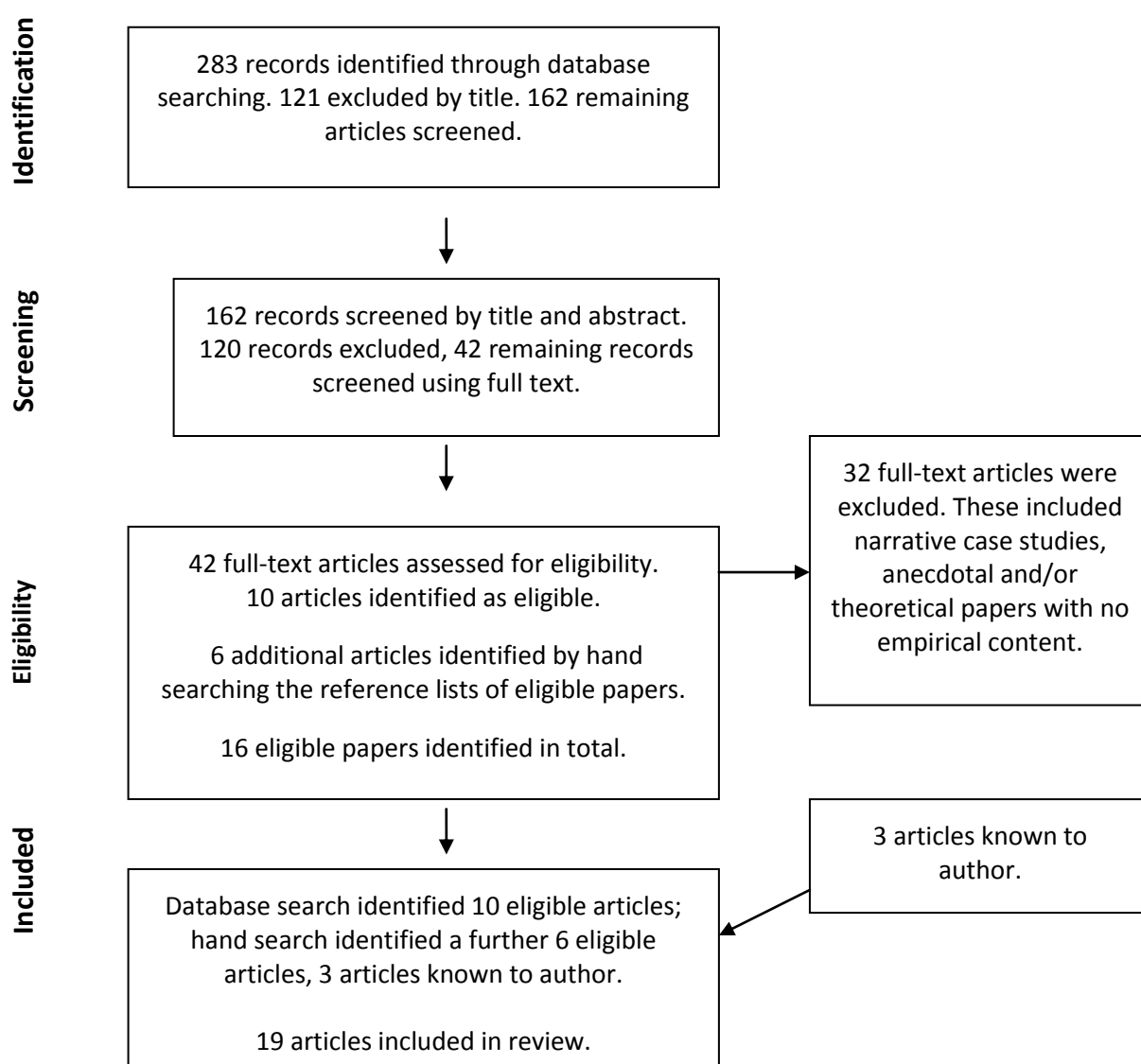
Method

A range of electronic databases were searched (PsychINFO, MEDLINE, Web of Knowledge, Cochrane Library) to identify appropriate literature by combining keyword searches using related synonyms (see appendix xi, p.137). To maximize access to the literature, no restrictions were made regarding the age range of participants, therapeutic stance, context of letter writing (e.g. traditional letter, email, letters as a therapeutic adjunct, 'Letter therapy'), date, methodological approach or other variables. The resulting literature was considered in terms of applicability by reviewing abstracts and article content. Additional literature was sourced by systematically examining references within relevant articles to assist in achieving adequate coverage. Figure one (p.4) summarises the outcome of the search process via a PRISMA diagram (Moher, Liberati, Tetzlaff & Altman, 2009).

Identified papers were assessed for their appropriateness to the current review. Papers presenting empirical research directly addressing the use of TLs as an adjunct to a therapeutic intervention were included. Papers solely addressing email correspondence, client's therapeutic writing (e.g. diary keeping), non-therapeutic or administrative letters, narrative case studies or exclusively

anecdotal content were excluded. The majority of the included literature is relatively recent (2001 onwards) with earlier research incorporated due to its specificity, relevance or unique contribution. This provides an overview of current thinking and synthesises relevant research. The therapeutic modalities represented are CAT (36%), Nursing (32%), 'Other' (incorporating Social Work, Counseling and Family Therapy; 21%) and Psychology (11%).

Figure 1. PRISMA Diagram Representing Search, Screening and Inclusion Processes of the Review.



Quality Control

The majority (n=13, 68%) of identified research utilised qualitative methodologies. These studies were evaluated using the Critical Appraisal Skills Programme (CASP, 2006) appraisal tool (see appendix xii, P. 139). The quantitative studies (n=4), were subject to the Downs and Black (1998) quality control checklist (appendix xiii, p. 144). In all cases higher scores represent greater methodological rigour (CASP, range 0-34; Downs & Black, range 0-32). Both tools were applied to the studies utilising mixed methods (n=2). Quality control scores were converted into percentages to allow cross-comparison. These author derived quality weightings are shown below in table one and are reflected in the conclusions drawn. An extended data table describing the key features, outcomes and quality ratings for each study is available in appendix xiv (p. 151).

Table 1. Author derived quality weightings of included research

Author/s	Quality Rating	
Qualitative		
Erlingsson (2009)	82%	
Freed et al (2010)	94%	
Hamill, Reid & Reynolds (2008)	97%	
Howlett & Guthrie (2001)	56%	
Moules (2002)	71%	
Moules (2003)	66%	
Moules (2009)	53%	
Pyle (2006)	89%	
Pyle (2009)	97%	
Rayner, Thompson & Walsh (2011)	85%	
Rodgers (2009)	44%	
Smithbattle, Leander, Westhus, Freed & McLaughlin (2010)	91%	
Vidgen & Williams (2001)	69%	
Quantitative		
Kellett (2005)	53%	
Kellett (2007)	50%	
Kellett (2012)	56%	
Wagner, Weeks & L'Abate (1980)	59%	
Mixed Methods	CASP	D&B
Evans & Parry (1996)	44%	44%
Shine & Westacott (2010)	91%	47%

IMPACT ON THE CLIENT

The impact of TLs on the client is the most researched area, with particular emphasis on subjective experience via qualitative analyses. Five qualitative studies have explored the effects of receiving TLs during therapy, (Pyle, 2006, 2009; Hamill, Reid & Reynolds, 2008; Freed, Dorcas, McLaughlin, Smithbattle, Leanders & Westhaus, 2010; Rayner, Thompson & Walsh, 2011; Moules, 2009) and one at termination (Howlett & Guthrie, 2001). The research is typified by small samples in unitary clinical populations, such as the elderly (Freed et al., 2010) or physical health patients (Howlett & Guthrie, 2001). Research was typically allied with a specific therapeutic approach (e.g. Psychodynamic-Interpersonal Therapy, Howlett & Guthrie, 2001; Family Therapy, Pyle, 2009) or profession (e.g. Nursing, Moules, 2002). This incorporated participants not actively seeking psychotherapy (Howlett & Guthrie, 2001) and those completing therapy long before participating in research (Moules, 2002, 2009). Four broad themes emerged from the qualitative data: (1) making connections, (2) extending the work of therapy, (3) managing endings, and (4) negative impacts. (The contributory facets of each theme are shown alongside the relevant references in appendix xv; p. 156). A single article employed a controlled quantitative research design to assess the effectiveness of letter interventions (Wagner, Weeks & L'Abate, 1980). This is described in the 'Therapeutic Outcomes' section alongside papers presenting research conducted in CAT. These include two mixed methods case series reviewing the short-term impact of letter interventions (Evans & Parry, 1996; Shine & Westacott, 2010), and three Single Case Experimental Design (SCED) studies (Kellett, 2005, 2007, 2012).

Making Connections

Experiences of feeling connected with others through TLs are often described within the literature. This sometimes depicted TLs enabling clients to share the work of therapy with family members (Howlett & Guthrie, 2001), but more commonly focussed on the therapeutic alliance. Early research conducted by Pyle (2006, 2009) used thematic analysis to identify client's experiences of receiving TLs. Pyle identified the theme '*Curiosity and Connection*'¹ describing the client's inquisitive reading of TLs and the implicit invitation to explore the contents further, drawing clients closer to the therapist. This was reported to deepen the client's sense of therapeutic connection and continued emotional support between sessions. Clients described TLs '*Consolidation*' effects upon therapeutic relationships, by providing tangible evidence of the clinician's commitment and care. This research is unique in its data gathering technique, whereby participants wrote letters to the researcher describing their experience of receiving a TL. Whilst a clear analytic process with well defined inclusion/exclusion criteria and apparently robust qualitative processes were apparent, participants were recruited by their therapist, potentially creating a positive selection bias. This is exacerbated by participants being prompted to consider the 'value and significance' of receiving TLs, potentially inhibiting negative responses. The two papers also draw from a single data set and are considered here as a single contribution.

Pyle's findings were corroborated by Hamill et al. (2008) who conducted semi-structured interviews with eight CAT clients to explore the subjective

¹ Themes are italicised throughout.

experience of receiving TLs. A thematic analysis informed by grounded theory and hermeneutics identified four key response categories: '*Making connections*' with (a) self, (b) therapist, (c) therapy, and (d) others (diagrammatically represented in appendix xvi, p. 159). '*Connecting to self*' referred to elevated self-awareness and understanding through a focus on psycho-emotional processes. Letters were perceived as 'offering a tangible reality', facilitating the assimilation of therapy and providing continuity. Client-therapist connections were augmented via perceptions of the therapist's conveyed care, commitment and respect; and recognition of the therapist as skilled and competent. Clients reported a growing awareness of the collaborative nature of therapy. '*Connecting to the therapy process*' described experiences of reformulation and ending letters 'framing' the therapy, as 'formal markers' providing opportunities for reflection. TLs were also seen to contain the potential to connect with others, offering a method of communicating 'self'. Despite the subjective nature of participant accounts and inabilities of the research to achieve data saturation, significant attempts were made to maintain methodological rigour and the research process was clearly articulated. However, these findings arise from a small sample of CAT clients. They may not represent the experiences of the wider clinical population, or be generalisable to other psychotherapeutic approaches or diagnoses. As this research included clients who reported therapeutic difficulties and dissatisfaction with services, this may account for the focus on 'connecting' as opposed to the consolidation effects described by Pyle (2006; 2009).

Client experiences of '*Feeling Known and Valued*', and connecting with the clinician ('*Reciprocity*') were also identified by Freed et al. (2010). Here TLs

conveyed a sense of the clinician's care, concern and respect for clients as individuals. Clients responded to the personalised nature of TLs, with an enhanced sense of collaboration and alliance with the clinician. Participants also felt they ceased to be an anonymous 'patient', humanising the therapeutic process. The study had the largest sample (n=27) in the available literature and employed a justifiable and robust analytic methodology. However, the results may be inflated due to the sample of elderly disabled participants, a particularly isolated and marginalised group for whom the significance of receiving TLs may have been enhanced. The findings are nevertheless consistent with those of Hamill et al. (2008), evidencing enhanced therapeutic connections following letter interventions.

Rayner et al. (2011) investigated client's experiences of the change process in CAT. This qualitative research utilised grounded theory and produced a theoretical model of client's experience of CAT (see fig 3, p.10). The model identified the perceived importance of CAT tools (reformulation and goodbye letters, and diagrammatic representations of the reformulation). The theme '*CAT tools*' was centrally located to reflect its interaction and influence with the related themes. In particular, reformulation letters were described as contributing to the structure and professionalism of therapy. The theme *CAT tools and 'being with the therapist'* described how the action of collaboratively negotiating CAT reformulation tools cemented the therapeutic alliance. A range of affective experiences including empowerment, hope, sadness, pain and shock were described in relation to receiving the TL. A 'containing and trusting' therapeutic relationship was therefore considered 'crucial'. Goodbye letters had less impact and were primarily perceived

as documenting progress. Both letters were linked to '*keeping it real*' via their role in clarifying and grounding client experiences in a tangible way, aiding self-awareness and identifying practical areas for change.

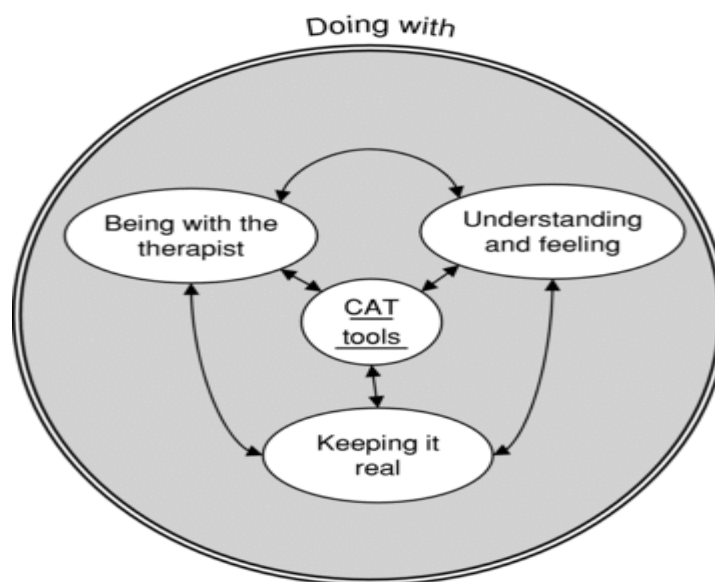


Figure 2. Clients' experience of the process of change in cognitive analytic therapy (Rayner et al. 2011)

Reformulation letters were credited with initiating the primary change process of aiding understanding (*CAT tools* and '*understanding and feeling*'). They were described as providing a new perspective and enhanced self-empathy, enabling clients to inhabit new positions regarding their problems. Post-therapy, reformulation letters were described as providing a record of prior functioning, a marker of progress, and maintaining connection with the therapist. Overall, clients described feeling actively engaged in working alongside CAT therapists ('*doing with*'). CAT tools played a significant role in this; clients who were active in the construction of tools and had emotional responses to the TLs, gained most benefit.

When clients felt ambivalent about the tools, the therapeutic relationship gained greater emphasis.

This research provided insight into clients' experiences of the creation, application, and helpfulness of TLs in CAT. The authors conclude that, as sharing formulatory information in written forms had no apparent negative impact on therapeutic alliances or progress, clients' experiences suggest CAT tools potentially provide an additional helpful aspect to therapy. However, the tools are utilised within a collaborative therapeutic dyad making it difficult to isolate variables. The three-stage analysis allowed for a responsive approach to interviews, data saturation was achieved prior to model development, and the emerging model was validated by additional participant interviews. Despite the methodologically rigorous approach, the small sample of predominantly female participants had previously reported subjective change post-therapy and so this reduced the potential for alternative experiences to be represented. Clients not reporting subjective change may have responded differently to CAT tools, and male client's views were underrepresented.

Managing Endings

Studies examining the effects of TLs often cite enhanced management of the termination of therapy as a key benefit; areas include the TL as a tangible transitional (Howlett & Guthrie, 2001), precious (Freed et al., 2010), and perpetual object (Pyle, 2006, 2009). The ability for the TL to function as a transitional object is considered helpful in managing endings, assisting clients to adjust to the loss of the therapist and any accompanying feelings of abandonment (Howlett & Guthrie, 2001). The tangible nature of TLs was described as allowing for the therapy and

therapist to remain 'alive' post therapy; linking with the role of TLs as precious objects providing '*tangible appreciation*' (Freed et al., 2010) and extending the therapeutic relationship. This theme was also identified by Pyle (2006, 2009) whose theme '*In perpetuity: The tangible and lasting presence of letters*' described the continued accessibility of the therapist through TLs following termination. Whilst only Howlett and Guthrie (2001) specifically addressed letters produced at termination there appears to be general agreement about the potential for TLs to enhance clients' effective management of the end of therapy. TLs produced at different stages of therapy are likely to differ in terms of their content and purpose. As a result, TLs may have different impacts in terms of their ability to augment coping at termination.

Extending the Work of Therapy

A number of researchers describe TLs preserving and continuing the work of therapy. TLs are proposed to protect and conserve therapeutic narratives, so they remain available to the client long after therapy ends. Howlett and Guthrie (2001) proposed that 'farewell' letters achieve this by providing a template for the ongoing assimilation of problematic experiences. The potential for TLs to promote '*Consolidation*' of learning by providing opportunities to reflect, focus upon, and assimilate session content also emerged in the work of Pyle (2009). In addition to aiding assimilation of problematic experiences, TLs may also function to promote wellbeing. Clients described how clinician's acknowledgement of therapeutic progress, and encouragement to continue to self-care were motivational, assisting them to embrace positive change, improving self-esteem and promoting recovery (Freed et al., 2010; Howlett & Guthrie, 2001; Pyle, 2009).

Another cited function of TLs is their ability to act as an aide mémoire. All of the studies presented here record the importance of TLs in 'remembering' the work of therapy. Pyle (2009) noted the 'tangible and lasting presence of letters' describing TLs as uniquely concrete accounts of therapy, which can be preserved and re-visited. In addition to promoting assimilation, this provided a marker for future progress. Clients described re-reading TLs to remind themselves of, or feel encouraged by, the therapeutic relationship post-therapy (Freed et al., 2010). This provided a tangible and enduring reflection of the relationship, which may otherwise be lost.

Howlett and Guthrie (2001) described TLs acting as a 'secure base' for remembering the therapy, providing a physical embodiment of the therapist. TLs are likened to transitional objects (Holmes, 1996), providing containment of the memory of therapy and holding a reformulation of the client's difficulties. The researchers suggested TLs offer enhanced potential for the resolution of interpersonal dilemmas, via revisions of autobiographical memory. Despite making interesting theoretical links, this research had poor internal validity. Findings represent a small sample (n=5) of case studies drawn from questionnaire data considering the perceived helpfulness of farewell letters. The methodology was unclear and questionnaire content un-reported. Participants were recruited one year post-termination and no rationale was provided for this delay. The authors make reference to a much wider participant population, but provide no inclusion/exclusion criterion for case selection. It therefore remains unclear if the presented cases are representative of particular clinical samples. Despite these

limitations, this paper is unique in specifically addressing farewell letters and in recruiting participants who did not actively seek psychotherapy, justifying its inclusion here.

Further support for TLs extending the work of therapy comes from Moules (2002, 2009) regarding the capacity of TLs to provide an enduring record of clinical work, documenting strengths and successes and carrying this information forward in time. TLs are presumed to afford the opportunity to remember, reflect, and revise behaviour, and provided 'visual affirmation' of the struggles faced by clients. Moules (2009) commented on the potential for TLs to expand clients' abilities to receive, process, and actively organise information, but cautions respect for the power and authority of the written word. However, both papers cited (Moules, 2002, 2009) appear to share a common data set and do not substantiate one another. Data collection employed a Hermeneutic methodology, recruiting exemplar families who had indicated the significance of TLs to their therapeutic journey. This positive selection bias potentially confounded results further weakened by the long period between therapy and the research. This perhaps explains why the potential for TLs to act as aide mémoires is a key finding of this research.

Negative Impacts

Despite numerous reported benefits of TLs, negative effects have also been documented. Pyle (2006) briefly described the potential of TLs to arouse negative emotional responses. When this occurred, the tangible nature of the letters encouraged continued rumination and recurrent re-experiencing of negative

affective states. This is consistent with Howlett and Guthrie's research (2001) where clients reported TLs invoking powerful distressing memories, particularly when participants had found it difficult to engage in, or benefit from therapy. Farewell letters in brief therapies (where outcomes are poor) may maintain a persecutory representation of the therapist, therefore having a detrimental impact (Howlett & Guthrie, 2001). Studies reviewing clients' subjective experiences of receiving TLs in CAT (Hamill et al., 2008; Rayner et al., 2011; Evans & Parry, 1996) also noted their potential to rouse negative affective responses (e.g. sadness, pain, shock).

Therapeutic Outcomes

A single controlled study assessed the impact of letter interventions as therapeutic adjuncts (Wagner et al., 1980). This research compared the effects of a manualised marital enrichment programme, with those of the programme plus either a paradoxical or linear (straightforward) letter. A control group received no intervention. Fifty-six couples were split evenly into four groups (not randomised); those receiving letters did so following session four of the six session intervention. Pre-post marital happiness, progress, and communication significantly positively improved across all intervention groups. Enrichment alone and enrichment plus paradoxical letter groups improved similarly, but the greatest improvement was seen in the enrichment plus linear letter group. These results suggest linear letters enhanced the effectiveness of the enrichment programme. The failure for paradoxical letters to perform equally, suggests the content of TLs is important and warrants further investigation. There were some major study limitations, the sample was drawn from a non-clinical population of psychology students and their

partners, who were not seeking help and required course participation credits. The method of group assignment is unclear and randomisation does not appear to have occurred. Despite these limitations this research is the only investigation utilising a control group and a quantitative methodology to assess the impact of TLs on client outcomes, thus providing an important insight into their effectiveness.

Research into the use of reformulation letters in CAT (Evans & Parry, 1996) explored their short-term impact upon client symptoms, the alliance and session helpfulness. Using mixed methods, a multiple baseline design employed sessional psychometrics across five sessions post-reformulation with CAT clients (n=4). A brief semi-structured interview considered subjective impact. No significant effects in relation to symptomology, alliance or helpfulness were found. Qualitatively, clients reported 'considerable emotional impact' of the TL, incorporating both positive responses such as improved understanding, focus, feeling heard/understood and increased trust, but also negative feelings regarding being 'overwhelmed' or 'frightened'. Such comments are consistent with the qualitative research presented in previous sections (e.g. Rayner et al., 2011). However, they represent individual quotations rather than a qualitative data analysis and should be regarded cautiously. There appears to be a discrepancy between the subjective experience of receiving TLs and psychometric outcomes. This may be related to the small sample and 'difficult to help' participant status, factors which potentially impacted upon the ability of the research to identify change. Further, the brief post-reformulation period neglected long-term assessment. This was potentially exacerbated by the inability to isolate stable pre-

intervention baselines prior to reformulation. Although it was considered unethical to withhold treatment until stable baselines emerged (Evans & Parry, 1996), this undermined internal validity of the study.

The aforementioned study was partially replicated in an attempt to extend the qualitative investigation and overcome noted methodological limitations. Shine and Westacott (2010) studied another case series of 'less severe' CAT clients (n=5). Enhanced measures of therapeutic alliance, in-session processes and symptomology were completed for four consecutive weeks pre and post reformulation. Again, no significant impact of reformulation letters was found. Semi-structured interviews conducted following the reformulation session were subjected to template analysis (Crabtree & Miller, 1992; cited in Shine & Westacott, 2010) identifying themes of: *'Feeling Heard'* (being listened to/understood and enhancing trust in the therapist). *'Understanding Patterns'* (the evolution and maintenance of unhelpful procedures). *'Space to Talk'* (sharing thoughts and feelings with a non-judgemental other), and linked with *'Feeling Accepted'* (intra and inter-personal processes of non-judgement and acceptance). *'Having Something Tangible'* (the ability of written documentation to extend beyond the therapy space, enhancing memory and aiding recognition and revision of problematic procedures). *'Working Together'* (the collaborative nature of the reformulation process, contributing to a sense of ownership, empowerment and control for clients). *'Feeling Exposed'* (clients discomfort at their personal disclosures in therapy and its recounting within the reformulation letter).

Many of the original weaknesses in Evans and Parry's (1996) research were not addressed in the replication study. The sample size remained small and cannot

be assumed to be generalisable to the wider clinical population. Again, the lack of a stable pre-intervention baseline undermined validity. Maintaining the short-term focus of the study overlooked cumulative and/or longer-term effects of reformulation, and neither study a control group. However, the qualitative data corroborates many of the concepts identified by qualitative studies regarding clients' experience of TLs (e.g. Hamill et al., 2008).

Additional insights into the CAT reformulation process are available via research employing Single Case Experimental Design (SCED). Three studies document cases of CAT with clients diagnosed with Paranoid Personality Disorder (PPD, Kellett, 2012), Histrionic Personality Disorder (HPD, Kellett, 2007), and Dissociative Identity Disorder (DID, Kellett, 2005). Whilst these studies did not seek to specifically study the impact of reformulation letters, the time series data highlighted changes associated with the TL. This provides insight into changes occurring following the introduction of the TL. Two of the above cases (Kellett, 2005, 2012) noted 'sudden gains' (significant reductions in target problems) immediately following the reformulation letter. Evidence of sudden gains in previously stable baseline data following a specific intervention suggests that the positive effects were produced by the applied TL technique (Bromley, 1986).

These SCEDs enhance knowledge of client and context specific effects of reformulation letters. They contribute to the identification of changes occurring directly in relation to the intervention and are termed event-shift sequences (Elliott, 2002). Well-controlled SCEDs provide empirical evidence equivalent to randomized controlled trials (Chambless & Hollon, 1998). Despite such strengths,

it must be acknowledged that these studies relied exclusively on self-report data, results were 'case specific' and had questionable generalisability. In the cases showing sudden gains, event-shift sequences occurred in some target symptoms (suspiciousness; Kellett, 2012; depersonalisation, identity confusion; Kellett, 2005), but not all. It may be that difficulties of this nature respond positively to the concrete, individualised and explicit nature of TLs. However, in the third case (Kellett, 2007) sudden gains were not evident, despite a similar typology of target problems (e.g. diffuse identity), rather progress was typified by incremental improvement. In the above cases the author acted as both researcher and therapist, allowing for greater case insight, but also potentially introducing bias. More research is warranted to investigate client responses to reformulation; utilising case series methodologies within a practice research network (Margison et al., 2000) could overcome some of the noted limitations.

Summary of the Impact on the Client

Despite wide variability in clinical populations, quality of methodologies and psychotherapeutic modalities, there appear some areas of consensus with regard to client's experiences of TLs. Overall these suggest TLs are largely beneficial. During therapy, TLs may be useful for enhancing interpersonal connectivity and extending therapeutic conversations, contextually and temporally. At termination, TLs may assist clients to manage endings and post-therapy, TLs provide an aide memoire thus extending the work of therapy. Potentially negative effects are the potential for TLs to arouse and perpetuate negative affect states during and post-therapy. The convergence of themes, despite the breadth of research, strengthens the cumulative findings. However, the quality

and quantity of research remains insufficient, especially given the potential for harmful negative effects. This intensifies the need for further robust and well-controlled investigations. The current evidence base also unhelpfully relies on a small clinical population, and limited group of researchers. There is a need for larger and broader samples, new research groups, more robust methodologies and research reaching beyond client's subjective experiences of receiving TLs.

Client's experiential accounts of receiving TLs in CAT combined with evidence of sudden gains from SCEDs offers some initial support regarding the impact, utility and helpfulness of reformulation letters. However this was not substantiated by the two pieces of research employing standardised measures. TL research in CAT has tended to unhelpfully focus on short-term evaluations of the impact of reformulation letters or case specific outcomes. Larger samples and truly longitudinal approaches could further clinical understanding and investigate possible cumulative effects. The reliance on case series and SCEDs significantly limits the generalisability of findings. The absence of deconstruction trials prevents comparisons between CAT conducted with or without TLs. The qualitative constructs identified by CAT research appear consistent suggesting commonalities of experience traversing clinical groups. However, there remains a paucity of empirical studies into the effectiveness of reformulation letters, and explicit research into the impact of CAT goodbye letters is notable in its absence.

Overall, there are clear methodological gaps in the TL effects literature; this includes longitudinal methodologies, sufficiently powered quantitative research methods, the use of control groups to isolate the effects of TLs, and the use of valid

and reliable psychometrics. The current state of knowledge does not therefore allow for solid conclusions to be drawn regarding TLs potential to augment treatment effectiveness, only that participants report facilitative and to a lesser degree, hindering effects. This requires closer examination due to the often dual-status of therapist as researcher, and the frequently identified potential for positive selection biases. Both of these issues potentially inflate positive outcomes and minimise representation of negative effects.

IMPACT ON THE CLINICIAN

The impact of TLs on clinicians has been much less studied. Two broad areas emerge; (1) clinicians experiences of writing and using TLs, and (2) the use of TLs as educational tools to progress the development of relational skills.

Therapeutic Letters in Practice

Two studies have researched the use of TLs in clinical practice. Vidgen and Williams (2001) employed a multiple case study approach to review the letter writing practices of six Clinical Psychologists. Grounded theory identified the following themes: *Typical Practices*; (utility of TLs as an aide memoire for reviewing session content, documenting shared understandings of presenting problems and agreed actions). *Use of Clinical And Micro Skills*; (TLs enhance engagement, evidence listening, accentuate client's strengths and clarify meanings). *Letters address the relationship with the client*; (therapeutic relationships were directly addressed within TLs, displaying direct and inter-professional respect for clients). *Messages to other professionals*; (TLs provided a vehicle for communicating the philosophical and working practices of clinicians

and services). *Beliefs about the family*; (clients were perceived to possess the resources to resolve their difficulties). These themes suggest TLs extend the reach of clinical skills and therapeutic relationships beyond the boundaries of therapy, accessing wider contexts where they can challenge personal and inter-professional client conceptualisations. Despite employing a fairly robust qualitative analysis incorporating participant feedback, this research represents the context-specific experiences of a small sample of clinicians and is at best speculative. The themes appear impoverished in terms of the potential use of TLs as therapeutic interventions, appearing to describe letters documenting therapeutic work and/or facilitating interprofessional communication. This may reflect the service culture surrounding TLs, alternative definitions of TLs, or a limitation of the research interview. Despite these concerns this research highlights the supplemental benefits of TLs in addressing wider, service level and inter-professional issues.

Pyle (2006) addressed the use of TLs by Counsellors operating primarily in narrative or solution-focussed approaches. Questionnaire data was categorised to identify three key themes concerned with (1) *the determining factors in deciding to send TLs*, (2) *the intentions of TLs*, and (3) *the components of TLs* (summarised in table 2, p.23). This research is unique in its attempt to access clinical decision making processes and intentions. However, the analysis comprised a simple categorical organisation of responses. Accordingly, conclusions cannot be drawn regarding the frequency with which items appeared. Reported practices might represent single responses rather than emerging themes. This research does little to enhance our understanding of TLs beyond anecdotal description, but does

provide some insight into the use and applications of TLs from clinical perspectives.

Table 2. Summary of themes (Pyle, 2006)

Determining factors	<ul style="list-style-type: none"> • TL was an established therapeutic component. • Counsellor desire to seek clarification and join with the client. • Perceived helpfulness of letters (to emphasise strengths, identify therapeutic gains and provide additional support). • Therapist time available to construct TL. • End of therapy (summarising, closing, and honouring the therapeutic work/relationship).
Intentions	<ul style="list-style-type: none"> • To validate the clients 'story', • Document strengths . • Sharing clinical understandings. • To encourage continuation of emerging ideas • Introduce questions, reflections or concerns.
Components	<ul style="list-style-type: none"> • Narrative that reinforced session content and utilised the client's language. • Questions (to promote client's between-session private reflections). • Reflective statements (to highlight strengths and review therapeutic progress).

Therapeutic Letters as Educational Aids

TLs have been examined regarding their potential educational value for developing clinical skills in Nursing practice. Research suggests that writing TLs can enhance nurses' abilities to focus upon client's strengths and resources, relinquish 'expert' roles, make theory-practice links (Erlingsson, 2009) and develop effective reflective/relational skills (Smithbattle, Leander, Westhus, Freed & McLaughlin, 2010).

Erlingsson (2009) employed a dual approach, analysing the content of TLs written by student nurses, alongside students' evaluative comments regarding the experience of the letter writing process. The content of TLs were analysed via the researchers subjective evaluation of their affectual impact, a content analysis and comparison with an un-validated quality control checklist. In addition, participants provided confidential written feedback regarding the letter writing process. Positive comments centred on the authorship process, content and formulation of TLs. Negative comments centred on the difficulties associated with constructing the letter. Unfortunately the clinician's experiences of letter writing were not subjected to any rigorous qualitative analysis. Erlingsson (2009) stated that the review of student's comments provided evidence of reflective thinking when planning and writing TLs, suggesting 'letter writing appeared to create a space where students could contemplate and reflect inwardly, outwardly, retrospectively, and prospectively'. This perhaps goes beyond what can be reasonably concluded however; attempts are made to situate the findings within theoretical understandings of reflective processes. Erlingsson (2009) proposes these findings unite the authorship of TLs with reflective practices, encompassing the potential for TL writing to create distance between situational and experiential factors. TLs are proposed to suspend clients in a 'space-time sphere' where they exist for the author in past, present and future tenses, thus offering a unique reflective position. It is through this impact on the clinician that TLs are proposed to hold the potential to facilitate therapeutic connections by linking clinician, theory and client and so enhancing clinical skills.

Smithbattle et al. (2010) built upon Erlingssons research by examining the impact of introducing a TL writing assignment in another graduate Nursing

training program. The development of relational and reflective capacities were key considerations. Seventy-four participants wrote two TLs (midway and termination) and focus groups were utilised to review the letter writing process, its impact on clinical learning and the development of helping relationships. Transcripts were subject to qualitative description analysis and coded, producing three broad themes: (1) *Process and Content of Letter Writing*; participants experienced letter writing as intimidating and anxiety provoking, but acknowledged the potential to validate client's emotions, strengths, achievements, challenges and future goals. Termination letters recorded therapeutic achievements and depicted what nurses had learned from clients. (2) *Impact of TLs on Clinical Learning*; TLs allowed participants to practice establishing client centred active professional relationships, balancing being too close/distant, and too formal/casual. (3) *Perceived Benefits for Clients*; positive feedback from clients receiving TLs validated their role in strengthening therapeutic relations through enhanced trust, receptivity, and disclosure. It was noted that a minority of 'disengaged' students devalued TL writing as inferior to other technical or academic tasks. The authors conclude that 'knowing the patient' is an underdeveloped skill, counter to scientific-technical expertise. However, the participants were undergraduate students, whose relational skills were still developing, potentially inflating these results. Further, it is difficult to separate the effects of TL writing here from accompanying processes of supervisor feedback and TL revision. How this issue was addressed is unclear and supervisor feedback may have been the primary active ingredient in enhancing student abilities. Future research addressing these concerns could broaden current understanding.

Summary of the Impact on the Clinician

Research into the use of TLs in developing professional practice is very limited, focussing upon practical issues above clinical utility. This contrasts with anecdotal evidence, emphasising the positive uses of TLs as therapeutic interventions (e.g. Rombach, 2003; Hoffman et al., 2010; Tuyn, 2003). Further investigations into how, when and why clinicians choose to use or disregard TLs would be of value. The use of TLs as an educational aid has tentative support. It appears writing TLs can enhance relational skills and the ability to empathise (Erlingsson, 2009). TLs may therefore have the potential to enhance therapeutic relationships and person-centred care by cultivating reflective processes, boundary recognition and management of termination issues (Smithbattle et al., 2010). However, TLs potentially offer an augmentation of clinical skills and this area deserves greater attention.

IMPACT ON THERAPEUTIC PROCESSES

Even less attention has been given to the impact of TLs on therapeutic processes. The identified research addresses the challenges TLs pose to therapeutic boundaries (Rodgers, 2009), and suggests an interactive cooperative enhancement relationship between TLs and the therapeutic alliance (Moules, 2003).

Therapeutic Boundaries

Rodgers (2009) investigated the potential for TLs to traverse conventional notions of therapeutic boundaries. Five clients volunteered to discuss their perception of the impact of TLs on the therapeutic relationship. Interpretative

phenomenological analysis (Smith, 1995) then identified five core themes; (1) '*Temporal and Spatial Boundaries*', (2) '*Therapeutic Intimacy*', (3) '*Mutuality*', (4) '*Availability*' and (5) '*Vulnerability*'.

In the theme '*Temporal and Spatial Boundaries*' TLs provided an extension of sessional conversations, contributing to increased feelings of therapist availability, investment and subsequent connectedness. TLs drew therapeutic conversations into the 'more private spaces' of participant's lives, enhancing connections between sessional insights and real life events. TLs were described as resolving the tensions between prescribed professionalisms and therapist transparency, enhancing '*Therapeutic Intimacy*' and providing objective evidence of the alliance. Letter writing was implied to enhance the therapists perceived '*Mutuality*', '*Availability*' and '*Vulnerability*', building relational connections. Rodgers (2009) describes the action of letters as facilitating individually negotiated boundaries, which enhanced patient-therapist experiences of 'connection and meeting, rather than separation and exclusion'. Despite producing clearly defined themes, this research provided insufficient participant quotations to justify them, a problem exacerbated by findings that closely reflect the researchers anticipated results based upon his clinical experience. Rodgers dual role as therapist-researcher and use of volunteer client participants created positive selection bias. This is potentially exacerbated by a failure to seek participant feedback or employ a third party 'reflective lens' to neutralise the effects of dual roles. No clear descriptions of the therapist's use of TLs or the applied methodology are provided.

Interaction with the Therapeutic Alliance

The manner in which TLs interact with the therapeutic alliance was the focal point for Moules' (2003) case study. A musical analogy is used to describe how the individual 'tones' of client and clinician must be recognisable and harmonious in TLs, if they are to produce the relational syntony that allows the written word to enhance therapeutic alliances and hence clinical effectiveness. The clinician needs to be willing to expose their 'self' and become vulnerable to being 'seen' by the client. The therapeutic relationship therefore provides the context for the TL, without which the words are potentially misinterpreted, irrelevant or insignificant. The relationship between the TL and therapeutic alliance is interactive with the potential to enhance healing, or promote separation. It is important for clinicians to recognise the potential for TLs to be misinterpreted without the possibility for immediate correction afforded by therapeutic conversations. This elevates the role of the therapeutic alliance; a strong alliance is likely to provide more robust protection against potentially damaging misunderstandings. Moules concludes that the character of TLs is relational and reciprocal, and their influence is inextricable from the space where therapeutic intention meets client interpretation. Two key points are made: (1) *The resonance of tone: Syntony, harmony and authenticity* are essential mediators of the effectiveness of therapeutic relationships and therefore TLs; and (2) letters can only be authored and interpreted in the context of the therapeutic relationship (*'Words in relationships'*). This research represents a very specific context; a single therapy incorporating three TLs and should be considered accordingly. This exemplar case study is drawn from a wider hermeneutic enquiry, but its representative nature with respect to this is unclear. Moules makes broad claims

regarding the interactive relationship of the therapeutic alliance and TLs. This exceeds the limits of the case presented, but does situate the findings contextually. Presenting the case description, participant interview data and suggested theoretical understandings together assists in illuminating the influence of TLs. However, they remain case specific and cannot be assumed to be generalisable.

Summary of the Impact on Therapeutic Processes

The impact of TLs on therapeutic processes deserves further investigation to enhance our understanding of when TLs may be most helpful, and when they potentially produce negative outcomes. Research often reports TLs acting to enhance the therapeutic alliance, with little notice given to potential damaging effects. This bias promotes the usefulness of TLs when an enhancement of the therapeutic alliance is desired. However, if issues of boundary transgression and interactive relational elements are inherent in the use of TLs, cases where there are deficits in the therapeutic alliance may require the greatest care from authors of TLs. Further research to clarify these issues and identify contraindicative factors would have clinical utility.

CONCLUSIONS

Methodological Limitations

There are very few methodologically sound empirical investigations into the effects of TLs across psychotherapies. The evidence base is heavily reliant on small sample sizes and case studies with attendant methodological limitations (Barker, Pistrang & Elliott, 2002) providing low levels of evidence quality (OCEBM, 2011). The qualitative research presented does provide some initial insights into

the experiences of clients and clinicians' with respect to TLs. However, research studies commonly fail to employ the stringent qualitative methodological features that minimise validity concerns and improve data quality (Morrow, 2005). Often dual therapist-researcher roles and evidence of active positive selection biases were apparent. Whilst Moules (2002, 2009) utilised appropriately documented purposive sampling, in many cases it appears unintentional and remains unaddressed within the research findings (e.g. Pyle, 2006). Such oversights have potentially created a positively skewed evidence base. Considerable emphasis has been given to the benefits of TLs, at the expense of studying potential limitations or hindering effects. Greater attention to these areas would have clinical utility and balance the evidence base. Quantitative methodologies are rare, and unhelpfully focus and rely upon short-term subjective self-report data. Quantitative research employing valid and reliable measures would enhance the evidence base. Attempts to isolate the effects of TLs using control conditions are evident in a single paper (Wagner et al., 1980). Greater methodological control across both quantitative and qualitative realms is therefore indicated. Research into TLs was rarely theory driven; as a result the conclusions and language often appear more plausible than the applied methodologies. Overall, there appears to have been greater interest in the experiences of TL authors or recipients over and above their potential impact upon symptom amelioration or clinical effectiveness. It is these areas that require focal attention, if the use of TLs in psychotherapy is to be advanced.

Clinical Implications

The limited and preliminary nature of research should be acknowledged when considering the potential clinical utility of TLs, but some tentative

recommendations can be made. With respect to TL content, evidence suggests that linear, as opposed to paradoxical letters, may have greater effectiveness (Wagner et al., 1980). This suggests content is important and greatest support is evident for CAT reformulation letters, whose content is theoretically derived (Ryle, 1994). Reformulation letters narratively feedback information gathered in the assessment process, explicitly linking problematic repetitive behavioural patterns with their developmental origins and possible expression in the therapeutic dyad (Ryle, 1994). The client's current presentation is therefore empathically described alongside target problems and their underlying maladaptive procedures (Ryle, 1994). TLs applying these criteria have tentative support. Other approaches make recommendations regarding TL content (e.g. family nursing, Moules, 2003), but these claims require further investigation. A review of the interplay between TL content and outcomes would further the current status of knowledge and test clinical utility. Despite providing limited evidence regarding content, the current literature suggests in general clients largely perceive TLs as useful. This appears enhanced when clients actively collaborate with therapists (Rayner et al., 2011), and are able to engage in, and benefit from therapy (Howlett & Guthrie, 2001). Short-term therapies where these conditions are not met may be contraindicated (Howlett & Guthrie, 2001); however in general few negative impacts are identified. TLs may be potentially helpful additional therapeutic tools (Rayner et al., 2011), when used with respect for their potential power and authority (Moules, 2009).

TLs reportedly possess a number of benefits in terms of enhancing therapeutic relations (e.g. Hamill et al., 2008), extending the work of therapy (e.g. Howlett & Guthrie, 2001) and providing an aide memoire (e.g. Pyle, 2009).

Research in general appears to suggest effective use of TLs requires an established therapeutic relationship and therefore their position (early, midway or late) in therapy appears important. However, no clear guidance is provided regarding the timing and appropriateness of TLs. Further research reviewing the position of TLs in therapy and potentially enhanced client coping regarding therapeutic endings would be a valuable addition to the literature. Preliminary research suggests that a co-operative enhancement between the therapeutic alliance and TLs may occur (Moules, 2003; Rodgers, 2009). This cautions against the use of TLs too early in therapy or where there are deficits in the alliance. The use of TLs in these cases may be contraindicated and further research would be valuable. Little can be said regarding the use of TLs produced at the close of therapy however, the potential for negative impacts (Howlett & Guthrie, 2001) suggests more TL research is needed.

Implications for Future Research

TLs are potentially powerful tools, which appear to exert a significant impact on clients, clinicians and therapeutic processes. Further research should seek to address identified gaps in the existing literature. Employing rigorous analytic processes could overcome the current limitations. The positive bias in existing research could be balanced by greater focus on the possible negative impacts or contraindications of TLs. Fertile areas for future research include examining the effectiveness of TLs to enhance therapy, reduce client distress and/or symptomatology, promote recovery, and reduce relapse rates (or vice versa). TLs lend themselves well to deconstruction trials, which could compare the efficacy of therapy conducted with or without TLs. Investigating the content, length

and position of TLs (early/mid/late therapy) in relation to clinical outcomes is also indicated. These areas are poorly addressed and further research would be valuable. At present TLs produced at the end of therapy have received minimal attention, despite being a recognised component of CAT (Ryle & Kerr, 2002) and a common feature of family nursing interventions (Moules, 2005). Research has reviewed the content of CAT goodbye letters (Turpin et al., 2011) and a useful next step would be to assess their effectiveness. Aside from direct therapeutic work, more research regarding the impact of TLs on therapeutic processes, their potential educational value and impact on clinical case formulation would enhance this emerging area.

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**The Efficacy of Narrative Reformulation of Depression in Cognitive Analytic
Therapy; a Deconstruction Trial**

Abstract

Objectives. To investigate (1) the efficacy of narrative reformulation (NR) in cognitive analytic therapy (CAT) for depression, (2) the impact of NR on the therapeutic alliance and perceived helpfulness and (3) provide initial practice-based evidence of the effectiveness of brief 8-session CAT.

Design. A randomised and controlled deconstruction trial compared standard CAT (NR-CAT, n =14) with CAT without NR (SDR-CAT, n =13). Data from both arms was utilised to examine overall effectiveness.

Methods. Measures were administered at screening, all treatment sessions and eight-week follow-up. The Patient Health Questionnaire was the primary outcome measure. The Working Alliance Inventory and Helpful Aspects of Therapy were also administered following all treatment sessions.

Results. NR did not enhance the efficacy of CAT for depression, the therapeutic alliance or helpfulness of therapy. Highly significant reductions in depressive symptomology were achieved for all pre-post analyses in the full sample. No patients were harmed or deteriorated in either arm.

Conclusions. NR does not appear crucial to the efficacy of CAT for depression. Eight-session CAT appears an effective treatment for depression in Primary Care. Further research regarding the clinical effectiveness and efficacy of CAT is recommended.

Practitioner Points

- 8-session CAT may be effective for treating depression in Primary Care.
- NR may not be necessary to produce therapeutic benefits.
- CAT is a user-friendly model for patients and therapists.
- Small sample. Therapists were not accredited CAT practitioners.

Introduction

Identifying the active ingredients of a psychotherapy

Extensive outcome research has validated the efficacy of psychotherapy for depression (e.g. Cuijpers, Van Straten, Andersson & van Oppen, 2008). However, identification of the ‘active ingredients’ of individual therapies implicated in outcomes has been slower to emerge. It is argued that interventions should seek to establish active ingredients and devise research models that can assess how they contribute to outcomes (Czaja Schultz, Lee & Belle, 2003). Methodologies that identify the distinct active ingredients of multimodal psychological interventions are termed component studies (Ahn & Wampold, 2001), or deconstruction trials (Carrico & Antoni, 2008). In these trials, the treatment arm of a randomised study investigates an isolated component within the intervention; this is employed to evaluate the efficacy of the identified component, and to compare differences between participants receiving (or not receiving) the component of interest (Kovach, Cashin & Sauer, 2006). This uncovers the relative impact and usefulness of explicit components of treatment (Green, 2006) and so highlights key mechanisms impacting on outcomes (Given, Given, Sikorskii, You, Jeon, Champion & McCorkle, 2010). In psychotherapy, focussing on the implementation of a single, operationally distinct unit of intervention offers the best opportunity for causal conclusions to be drawn (Czaja et al., 2003). To maximize this potential, it is recommended that treatment delivery adhere to standard clinical practice and the superior control condition is treatment as usual (Green, 2006).

Deconstructing psychotherapy for depression

Numerous studies have attempted to deconstruct psychotherapy to uncover the active ingredients for treating depression (Longmore & Worrell, 2007; Ahn & Wampold, 2001), with a particular focus on the efficacy of Cognitive Behaviour Therapy (CBT). Studies include between-subjects 'dismantling' or 'additive' designs (Ahn & Wampold, 2001). Dismantling designs compare a whole treatment, with treatment minus a specific theoretically important component (e.g. Jacobson et al., 1996), whilst additive designs provide an additional specific component hypothesised to enhance outcomes (e.g. Propst et al., 1992). Research has also utilised within-subjects designs, delivering separate components of CBT to the same participants in discrete treatment phases (e.g. Zettle & Hayes, 1987; Jarrett & Nelson, 1987).

Comprehensive reviews of the CBT component literature (Ahn & Wampold, 2001; Longmore & Worrell, 2007) illustrate equivalence between components when compared. For example, a component analysis of CBT for depression found equivalence for Behaviour Activation (BA) compared to complete CBT (Jacobson et al., 1996). This evidence enabled BA to become a 'stand alone' treatment for depression (Mazzucchelli, Kane & Rees, 2010). In addition, specific techniques have been identified as having particular value for discrete diagnoses (e.g. exposure response prevention for obsessive compulsive disorder; Lambert, 1992). This suggests some of the differences in improvements acquired through psychotherapy are attributable to distinct features, independently linked to specific therapies. This has implications for shortening treatment duration and increasing treatment acceptability by only delivering the active ingredients and so improving the quality of specific factors predicting therapeutic outcomes

(Llewelyn & Hardy, 2001). Research comparing components of overall treatments to assess their contribution to outcome therefore has significant clinical and health economic value. A recent meta-analysis of the comparative outcome research of psychotherapeutic treatments for depression (Cuijpers, Straten, Andersson & van Oppen, 2008) suggested future research should strongly concentrate on identifying the discrete factors implicit in generating improvement.

Narrative Reformulation in Cognitive Analytic Therapy

Cognitive analytic therapy (CAT) is a brief structured psychotherapy (typically 16 or 24 session intervention) drawing upon elements of cognitive and psychodynamic psychotherapies (Ryle & Kerr, 2002). In terms of specific components, CAT uses discrete interventions at identified time points during therapy, such as the narrative reformulation (NR), sequential diagrammatic reformulation (SDR) and goodbye letters at termination (Kellett, 2012). NRs explicitly label and link problematic repetitive procedures with their developmental origins (Ryle, 1991) and discuss their potential expression within the therapeutic relationship (Ryle & Kerr, 2002). Whilst NR is considered a crucial therapeutic task and assumed to be a 'powerful agent of change' (Ryle, 1994), the evidence base for the effectiveness of NR is slight (Hamill, Reid & Reynolds, 2008).

While extant research has reviewed the accuracy (Bennett & Parry, 1998; Ryle, 1995) and impact of reformulation (Ryle & Beard, 1993; Bennett, 1994), investigations into the effectiveness of NR have unhelpfully focussed on short-term evaluations of impact (Evans & Parry, 1996; Shine & Westacott, 2010). Both studies found NR had no effect upon client symptoms, therapeutic alliance, or the perceived helpfulness of sessions. However, research utilising single case

experimental design (SCED) methodologies has identified evidence of significant reductions in target problems immediately following the introduction of NR (Kellett, 2005, 2012). This evidence of 'sudden gains' in previously stable baseline data is suggestive of an event-shift sequence (Elliott, 2002), whereby positive effects appear attributable to the applied technique (Bromley, 1986). Qualitative research reviewing clients' experience of NR identifies enhanced feelings of connection with self, therapist, therapy and others, augmenting intra and interpersonal functioning (Hamill et al., 2008). The contribution of NR to the structure and professionalism of CAT was identified by Rayner, Thompson and Walsh (2011), who found the collaborative negotiation of NR in therapeutic dyads cemented the alliance and initiated change processes. However, NRs also have the potential to provoke significant and troubling affective experiences such as sadness, pain and shock (Hamill et al., 2008; Rayner et al., 2011; Evans & Parry, 1996).

Rationale

A discrepancy exists between qualitative evidence attesting to the subjective impact of NR (e.g. Hamill et al., 2008) and the lack of quantifiable outcomes (e.g. Shine & Westacott, 2010). The paucity of NR studies in CAT (Hamill et al., 2008) is exacerbated by clear methodological problems in the extant studies such as small samples and lack of usage of valid and reliable psychometrics. This research is unique in employing a deconstruction trial methodology (Carrico & Antoni, 2008), to isolate the efficacy of NR by comparing CAT conducted with or without NR. This adds to the nascent CAT evidence base by addressing the impact of NR on therapeutic processes and outcomes. This contributes to theoretical

understandings of the active ingredients of CAT, and specifically the stated role of NR. Given the theoretical importance of NR in CAT and the growing popularity of the model (Marriott & Kellett, 2009), consideration of the effectiveness of NR as a central component of CAT is warranted. This research also seeks to provide initial practice-based evidence (Barkham et al., 2001) for the use of a brief (8-session) CAT intervention for the treatment of depression in Primary Care. No previous research has been identified which seeks to evaluate a brief CAT intervention in this population. However, CAT is increasingly used in primary care settings (Ryle & Kerr, 2002) where a naturalistic evidence base is emerging regarding its effectiveness for treating depression (Dunn, Golyukina, Ryle, & Watson, 1997; Marriott & Kellett, 2008). Exploring the potential utility of brief CAT in this context provides a test of whether CAT can match the service demands of Primary Care.

Aims

The study aims to:

1. Isolate the efficacy of NR in depression by comparing outcomes (symptom amelioration) for patients randomised to NR (NR-CAT) or no NR (SDR-CAT).
2. Investigate the impact of NR with clients displaying symptoms of depression in terms of:
 - (a) The therapeutic alliance
 - (b) The perceived helpfulness of therapy
3. Provide initial practice-based evidence of the effectiveness of 8-session CAT for clients displaying symptoms of depression.

Hypotheses

Clients receiving NR will:

1. Achieve better outcomes (greater symptom amelioration) in comparison to clients randomised to CAT without NR (SDR-CAT).
2. Report enhanced therapeutic alliances in comparison to clients randomised to CAT without NR (SDR-CAT).
3. Perceive CAT as more helpful in comparison to clients randomised to CAT without NR (SDR-CAT).

Method

Ethics

This research was subject to ethical review prior to commencement. Ethical and governance approvals were provided via the Integrated Research Application System (IRAS), Barnsley Primary Care Trust and South West Yorkshire Partnership NHS Foundation Trust respectively. The ethical implications of removing a theoretically important feature of CAT were considered. The current evidence base for NR is limited. However, existing research suggested no impact upon symptom amelioration, the therapeutic alliance, or the perceived helpfulness of therapy (Evans & Parry, 1996; Shine & Westacott, 2010) alleviating preliminary concerns.

Participants

Participants were working age adults recruited via a Primary Care, Improving Access to Psychological Therapies (IAPT) service. Patients awaiting treatment with a primary presenting problem of depression were invited to an initial screening appointment conducted by the CAT team. In total sixty-eight

patients were screened; forty-four females (64.70%) and twenty-four males (35.30%), with an age range of 19-65 years (mean 41.22, SD 12.0).

Recruitment

Patients were screened for suitability by the CAT team. The presence of depression was ascertained via clinical interview, using the DSM-IV (American Psychiatric Association, APA; 1994) criteria for identifying a Major Depressive Episode. Severity of depression was categorised using the Patient Health Questionnaire (PHQ9, Spitzer, Kroenke & Williams, 1999). Patients with PHQ9 scores in the mild to moderately severe ranges (5-21) were considered immediately suitable; scores over 21 were reviewed on a case-by-case basis. The following exclusion criteria were applied: co-morbid mental health diagnoses, significant risk issues, history of overdoses or other self-injury, current substance misuse, considerable previous contact with mental health services (two or more prior episodes without significant change), previous inpatient admission for mental health difficulties, a stated reluctance to engage in psychotherapy, difficulties that impaired access to therapy materials (e.g. literacy difficulties, visual impairments), where English was not the participant's preferred language and clients withdrawing from therapy prior to reformulation. Patients meeting the above criterion were provided with an information sheet (appendix ix, p.126) explaining the research and inviting participation. Those agreeing to participate signed a consent form (appendix viii, p.124) stating the voluntary nature of participation, confidentiality, and the right to withdraw at any time was stated. Once consent was established CAT commenced at the earliest opportunity.

Therapists

Trainee clinical psychologists (n=4) in their final year of training provided the CAT. To ensure model adherence, consent was sought to audiotape therapy sessions for supervision purposes. A Consultant Clinical Psychologist who is a qualified and supervisor-trained CAT practitioner reviewed session tapes and facilitated a weekly supervision group of 90 minutes throughout the duration of the study. Excerpts of session tapes were reviewed during all supervision sessions. Supervisee's either selected an excerpt they wished to receive specific input on (e.g. to ensure model fidelity, identify ruptures/enactments or seek therapeutic guidance) or excerpts were selected at random. In addition, the supervisor regularly listened to entire sessions providing written and verbal feedback regarding model fidelity, style, therapeutic content, alliance and intervention. Written therapeutic materials were also reviewed before being presented to participants. All reformulation documents (NR and SDR) were provided for supervisor feedback and recommendations were made to enhance therapeutic content.

Design

A randomised and controlled deconstruction trial methodology was employed (as described by Carrico & Antoni, 2008). Participants were randomly allocated into one of two active study arms (NR-CAT or SDR-CAT) using the GraphPad (2005) computer randomisation software package. Participants were blind to their group assignment. To minimise therapist effects individual randomisation sequences were created for each therapist, thus distributing participants in each arm across the team. Measures were matched in each arm and

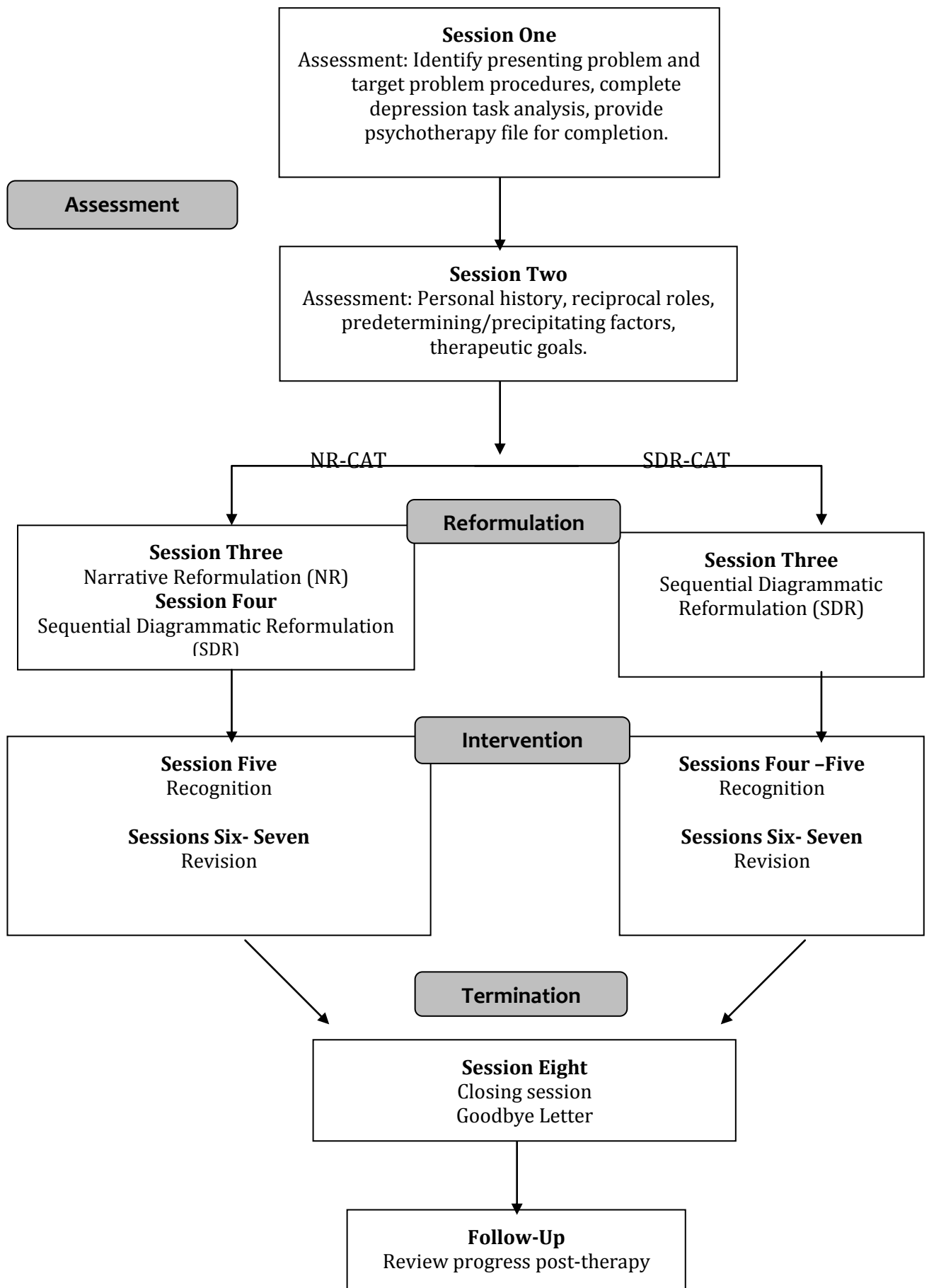
taken on a session-by-session basis at screening, across the eight-session treatment and at an eight-week follow-up.

Treatment model

In CAT the therapeutic contract can be shortened where 'the threshold to consultation is low' and symptomology suggests mild disturbance (Ryle & Kerr, 2002). Working within predetermined time limits heightens the therapeutic process whilst protecting against over-dependence; hence time-limited CAT interventions are suggested to be as clinically effective as lengthy therapy for most patients (Ryle & Kerr, 2002).

All participants received eight sessions of CAT, with a follow-up appointment eight weeks post-therapy. Assessment took place over the first two sessions and at session three those in the NR-CAT arm received a NR, whilst participants in the SDR-CAT arm received a SDR. The NR-CAT arm received the SDR at session four. The remaining sessions in both arms were dedicated to producing 'exits' on the SDR to reduce depression. Exits are the change methods in CAT and consist of indicated cognitive, behavioural and interpersonal changes negotiated within the therapy (Kellett, 2007). An exit may also include within-therapy change by analysing the reciprocal roles between patient and therapist (Kellett, 2007). Patients in both arms received, and were invited to produce goodbye letters at termination (session eight). All participants were invited to attend a follow-up session approximately eight weeks post-therapy. (Structure depicted in figure 3, p.51).

Figure 3. Structure of session content



Measures

Outcome Measures

The following self-report outcome measures were completed at screening, each of the eight sessions and at follow-up. The first three measures constitute the IAPT minimum data set (IAPT, 2011).

The Patient Health Questionnaire (PHQ9; Spitzer, Kroenke & Williams; 1999).

A nine-item measure of depression with items derived from DSM-IV classifications pertaining to lowered mood and physiological changes. Scores range from 0-27 (severity ratings are categorised as severe 20>, moderately severe 15>, moderate 10>, mild 5>, remission <5.) The recommended cut-off of 10 or above demarcates clinical caseness; sensitivity and specificity at this point have been identified at 92% and 80% respectively (Gilbody, Richards, Brearley & Hewitt, 2007). The PHQ9 has good reliability in Primary Care samples (Kroenke, Spitzer & Williams, 2001).

The Generalised Anxiety Disorder Assessment (GAD7; Spitzer, Kroenke,

Williams & Lowe; 2006). This is a 7-item measure of generalised anxiety that ranges from 0-21 (severity ratings are categorised as severe 15>, moderate 10>, mild 5> & remission <5). The recommended clinical cut off is 8 and above. However, applying a threshold score of ten affords 89% sensitivity and 82% specificity (Swinson, 2006). GAD7 also has satisfactory sensitivity and specificity for the detection of other anxiety disorders (e.g. panic disorder, social anxiety disorder; Kroenke, Spitzer, Williams, Monahan & Lowe, 2007). The GAD7 has good reliability in Primary Care samples (Spitzer, Kroenke, Williams & Lowe, 2006).

The Work and Social Adjustment Scale (WSAS; Marks, 1986). A 5-item measure, assessing the impact of mental health difficulties on aspects of daily functioning (e.g. work, home management, relationships) and is a measure of disability. It is a valid, reliable measure displaying good internal consistency and test-retest correlates. Scores are recognised as sensitive to disorder severity and change arising through treatment (Mundt, Marks, Shear & Greist, 2002). The WSAS has good reliability in Primary Care samples is identified as 0.82 (Qureshi, 2012).

Process Measures

The following self-report measures were completed following sessions one-eight:

Helpful Aspects of Therapy (HAT; Llewelyn, 1988; Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozen, 1988). A 7-item qualitative measure of client perceptions of significant events in therapy. The HAT invites clients to describe and rate helpful and hindering events in therapy sessions. This data is used to identify therapeutic processes potentially associated with change (Elliott, 2002).

Working Alliance Inventory-Short (WAI-S; Tracey & Kokotovi; 1989). A twelve-item measure assessing therapeutic alliance; the three subscales pertain to (1) task, (2) goal agreement and (3) therapeutic bond. Items are scored on a 7-point likert scale. The WAI has strong internal (Busseri & Tyler, 2003) and test-retest reliability (Martin, Garske & Davis, 2000).

Analysis

Assuming a 'medium' effect size of $f = .25$, a significance level of $\alpha = .05$, and two study arms providing data at four time points (pre-therapy, reformulation, completion of CAT, and follow-up) a total sample size of 24 gives 80% power to test differences between NR-CAT and SDR-CAT using ANCOVA. There was also sufficient power to conduct trend analyses to investigate patterns of change over time (sessional data). Assuming a 'medium' effect size ($f = .25$), a significance level of $\alpha = .05$, and two study arms providing eight data points (sessional data excluding follow-up) a sample size of 24 gives 95% power.

Reliable change index (RCI) rates will be calculated using the Jacobson & Truax (1991) metric for small ($z > 1.96$, $p < .05$), medium ($z > 2.58$; $p < .01$), and large ($z > 3.29$, $p < .001$) effect sizes. Change is calculated as the difference between a patients' scores on the PHQ9 across two measurement phases, treatment (assessment- termination) and contact (screening – follow-up). PHQ9 scores of 10 or above identify clinical caseness (Gilbody et al., 2007). Patients are categorised as 'Recovered' (reliable improvement plus movement from caseness to non-caseness), 'Improved' (reliable improvement, no change in caseness), 'Deteriorated' (reliable deterioration), and 'Harmed' (reliable deterioration plus movement from non-caseness to caseness). Patients making no reliable change in either direction represent 'Stasis'.

The results section is divided into:

- (1) ANCOVAs will examine the difference in clinical efficacy between NR-CAT and SDR-CAT in terms of depression, anxiety and disability.
- (2) Assessments of reliable and clinically significant improvement and deterioration in each arm will be calculated and compared on pre-post data using the RCI (Jacobson & Truax, 1991).
- (3) ANCOVAs will examine the difference in clinical efficacy between NR-CAT and SDR-CAT in terms of helpfulness and the therapeutic alliance.
- (4) The effectiveness of CAT for depression will be analysed by combining the two study arms. Paired sample T-Tests will examine symptom change at key study time points. A content analysis of the qualitative data from the HAT will review the overall perceived helpfulness of CAT.

Results

Screening, Treatment and Follow-Up Compliance

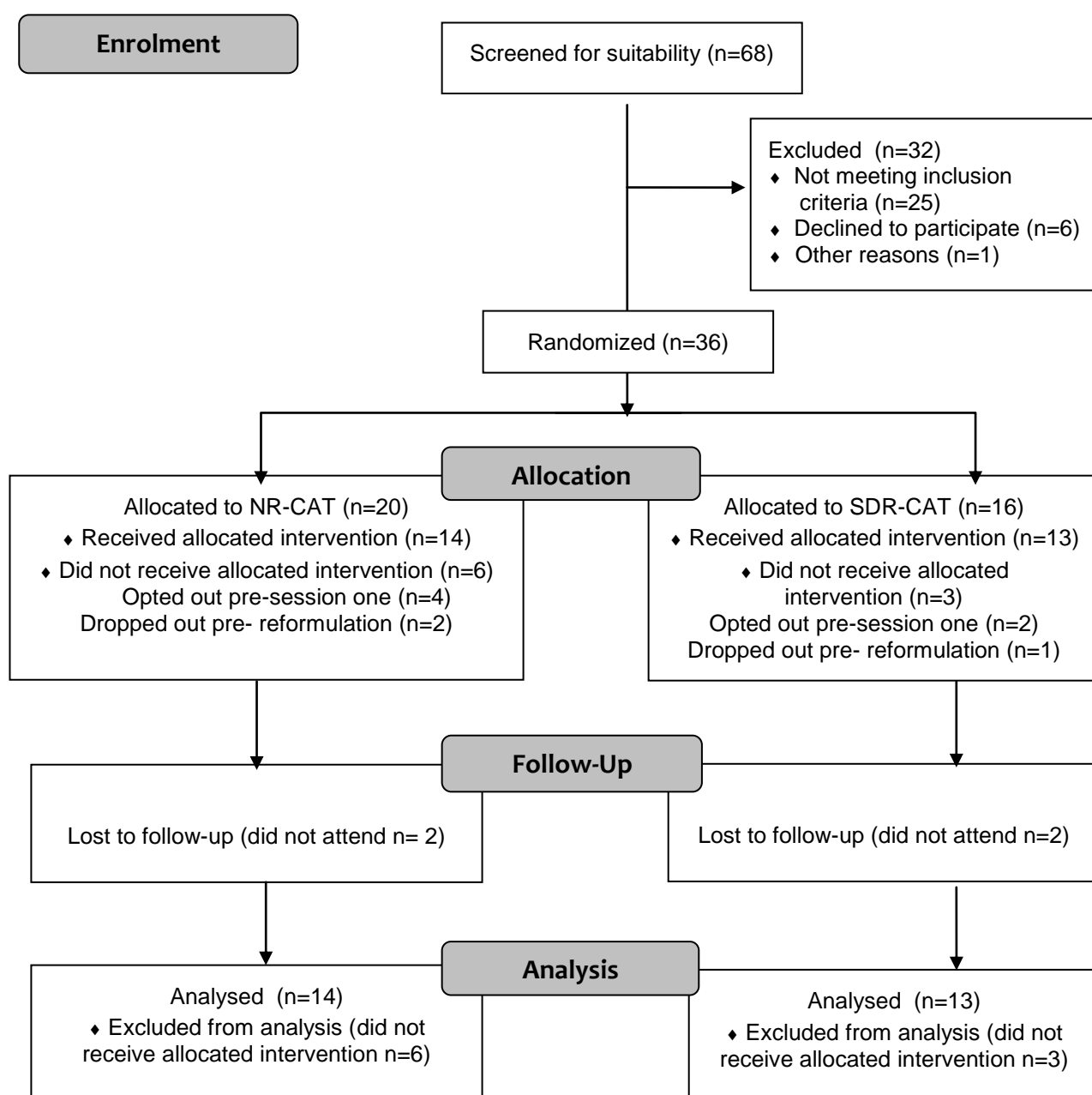
Sixty-eight patients were screened for suitability, of which 32 (47%) did not meet the inclusion criteria or chose not to participate. Thirty-six (52.9%) were deemed suitable before randomisation. Six (16.7%) patients opted out of CAT prior to beginning treatment (n=4 NR-CAT, 11.1%; n=2 SDR-CAT, 5.6%). Three patients dropped out prior to reformulation (8.3%) and were excluded from the final analysis. Of the 30 participants who attended session one, 27 (90%) completed the full eight-session treatment and 23 (85.2%) attended follow-up. Participant pathways are displayed in the Consort Diagram (Schulz, Altman & Moher, 2010; figure 4, p.57). Following reviews at follow-up, two patients (one from each arm) were referred on for additional therapy (CBT).

Data Completeness

For the twenty-seven patients completing therapy, there were high levels of data completeness (96.3%). With a single exception, data was provided at every key time point (99.07%; screening, pre-therapy, reformulation and post-therapy). Four participants did not attend follow-up. Excluding these cases, follow-up data completion achieved 100%. Where data was unavailable, the last observed score was carried forward (LOCF, Streiner & Geddes, 2001) for analysis purposes. With respect to the WAI, data completeness rates were also high (89.81%); missing data was accounted for using LOCF, when this was unavailable the missing session was excluded from analysis. HAT data achieved much lower completion rates (28.7%), due to measures returned uncompleted. Where participants had chosen not to

complete the HAT the score was recorded as zero, missing data was excluded from the analysis. Mean session ratings were used to assess the overall helpfulness of sessions.

Figure 4. Consort diagram showing participant pathways through screening, treatment & follow-up.



Randomisation; participants and initial scores

With respect to age, there were no significant differences between the arms ($t(25) = .192$, $p = .849$, see table 3, p.58) and visual inspections of histograms indicated normal distributions. Levene's test of equality of error variance was non-significant ($F(1, 25) = .198$, $p = .660$). Gender was also equally distributed across the arms (Fishers $p=0.68$; NR-CAT 21.4% male, 78.6% female; SDR-CAT 30.8% male, 69.2% female).

Means and SDs for all measures at point of entry are shown in table three, p.58. There were no differences between the arms at screening for depression (PHQ9; $t(25) = .665$, $p = .512$), anxiety (GAD7; $t(25) = .210$, $p = .835$) or disability (WSAS; $t(24) = .384$, $p = .704$). Levene's test of equality of error variance was non-significant for all measures (PHQ9; $F(1, 25) = .294$, $p = .592$), (GAD7; $F(1, 25) = .039$, $p = .845$), (WSAS; $F(1, 24) = .1353$, $p = .256$), (WAI; $F(1, 23) = .011$, $p = .917$), (HAT; $F(1, 24) = .427$, $p = .520$). These checks indicate randomisation was successful.

Table 3. Demographics and scores on measures for NR-CAT & SDR-CAT at initial measurement.

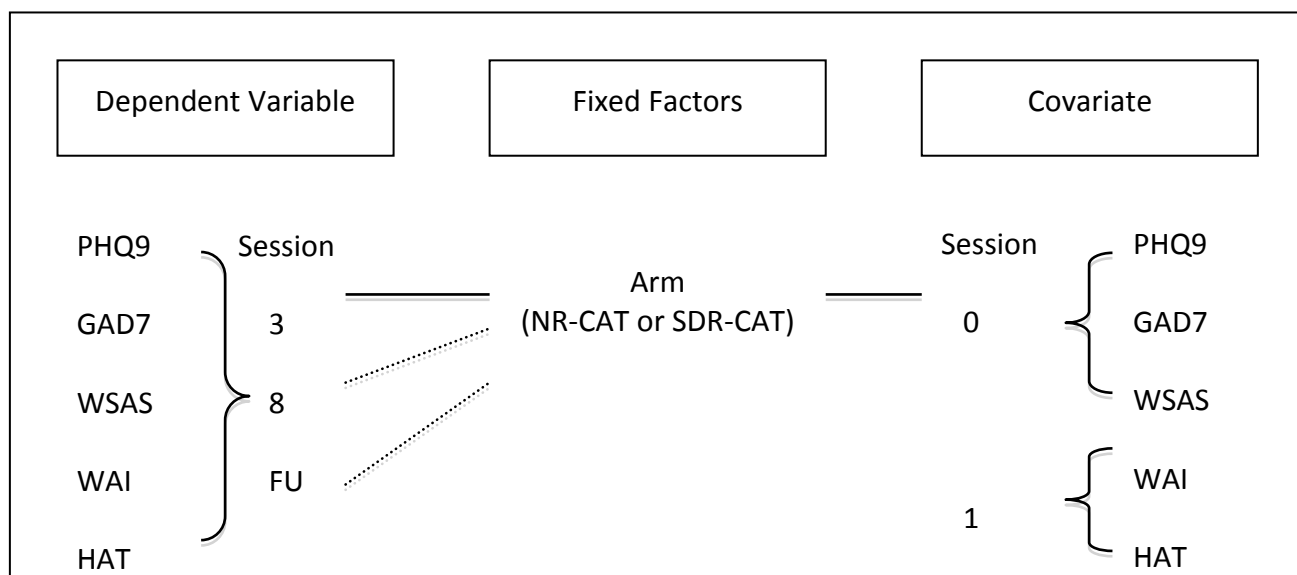
		Arm	N	Mean	Std. Deviation	Std. Error Mean
Participants	Age	NR-CAT	14	40.79	12.211	3.263
		SDR-CAT	13	41.69	12.257	3.399
	Gender	NR-CAT	14	15.21	5.102	1.363
		SDR-CAT	13	13.85	5.595	1.552
Outcome Measures	PHQ9	NR-CAT	14	15.21	5.102	1.363
		SDR-CAT	13	13.85	5.595	1.552
	GAD7	NR-CAT	14	10.93	5.704	1.524
		SDR-CAT	13	10.46	5.854	1.624
	WSAS	NR-CAT	13	19.00	9.738	2.701
		SDR-CAT	13	17.69	7.488	2.077
Process Measures	WAI	NR-CAT	12	59.75	15.927	4.598
		SDR-CAT	13	65.23	13.572	3.764
	HAT	NR-CAT	14	7.857	5.6002	1.4967
		SDR-CAT	12	12.125	6.0269	1.7398

(1) The efficacy of NR-CAT and SDR-CAT for depression, anxiety and disability.

Repeated ANCOVA was used to explore differences between the arms at the following time points: screening, assessment, reformulation, termination, and

follow-up (sessions 0, 1, 3, 8 and 9 respectively). Visual inspections of histograms indicated normal distribution of data. The testing model is shown below in figure five.

Figure 5. Testing model for repeated ANCOVA.



Depression

There were no significant differences between NR-CAT and SDR-CAT for depression outcomes at reformulation, termination or follow up, when scores were adjusted using PHQ9, GAD7, WSAS, WAI, or HAT screening scores as covariates. Table four reports (p.60) the ANCOVA and figure six (p.61) displays the outcome trend for depression for NR-CAT and SDR-CAT.

Anxiety

There were no significant differences between NR-CAT and SDR-CAT in terms of anxiety at reformulation ($F(2,24) = .505$ $p = .484$), termination ($F(2,24) = 1.307$ $p = .264$) or follow-up ($F(2,22) = 1.296$ $p = .267$) when scores were adjusted using GAD7 scores at screening as a covariate. Table five (p.60) reports the

ANCOVA and figure seven (p.61) displays the outcome trend for anxiety in NR-CAT and SDR-CAT.

Table 4. ANCOVA and effect sizes (ES) for depression outcomes.

Covariate	Dependent Variable	F value	Significance	ES (d)
PHQ9 Screening	PHQ9 (reform)	F (2,24) = .009	p = .926	.039
	PHQ9 (post)	F (2,24) = .074	p = .787	.111
	PHQ9 (f-u)	F (2,23) = .012	p = .914	.046
GAD7 Screening	PHQ9 (reform)	F (2,24) = .244	p = .626	.202
	PHQ9 (post)	F(2,24) = .200	p = .659	.183
	PHQ9 (f-u)	F(2,23) = .223	p = .641	.197
WSAS Screening	PHQ9 (reform)	F (2,23) = .139	p = .713	.156
	PHQ9 (post)	F(2,23) = .458	p = .505	.282
	PHQ9 (f-u)	F(2,22) = .411	p = .528	.273

Table 5. ANCOVA and effect sizes (ES) for anxiety outcomes.

Covariate	Dependent Variable	F value	Significance	ES (d)
GAD7 Screening	GAD7 (reform)	F (2,24) = .505	p = .484	.291
	GAD7 (post)	F (2,24) = 1.307	p = .264	.468
	GAD7 (f-u)	F (2,22) = 1.296	p = .267	.485

Figure 6. Trend of sessional mean scores for PHQ9 for NR-CAT & SDR-CAT.

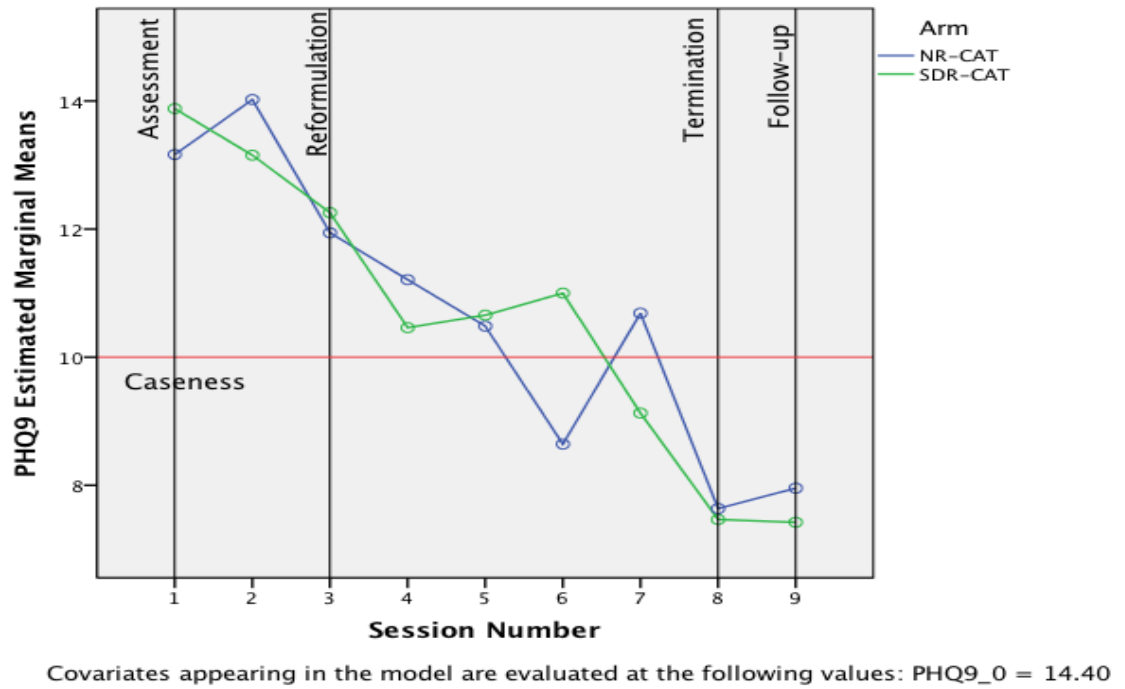
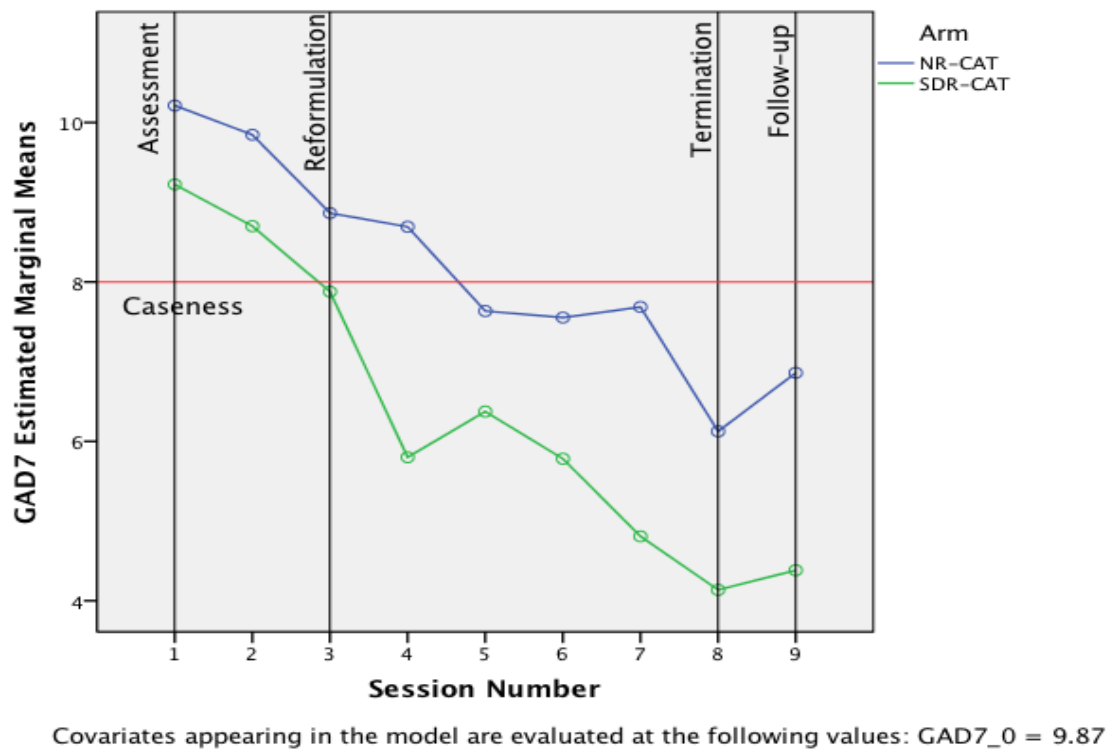


Figure 7. Trend of sessional mean scores for GAD7 for NR-CAT & SDR-CAT.



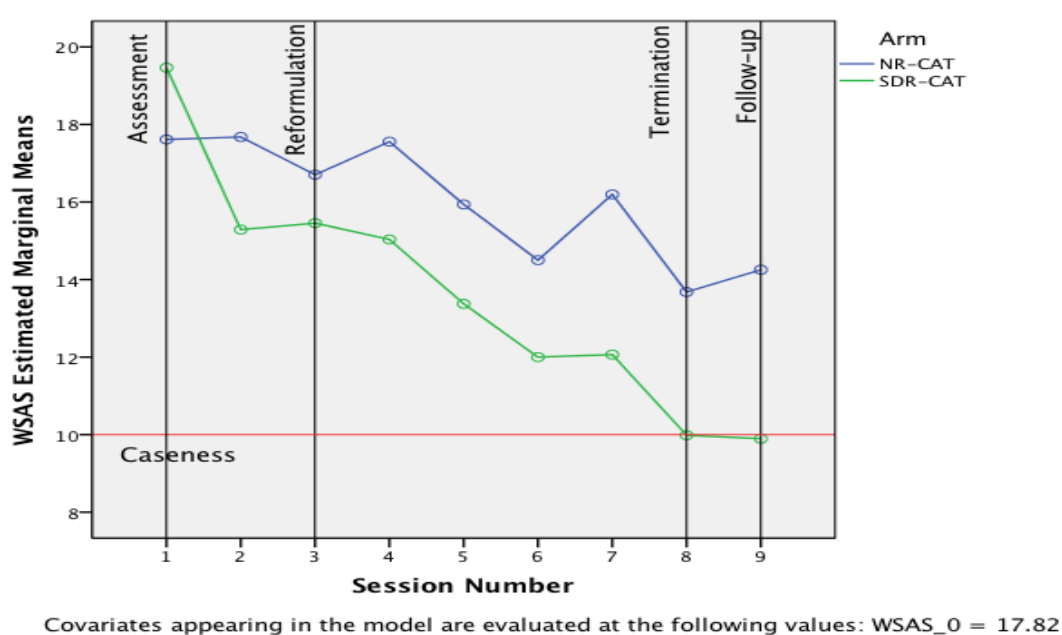
Disability

There were no significant differences between NR-CAT and SDR-CAT on WSAS scores at reformulation ($F(2,23) = .000$ $p = .995$), termination ($F(2,23) = .524$ $p = .476$) or follow-up ($F(2,21) = .386$ $p = .541$) when scores were adjusted using WSAS scores at screening as a covariate. Table six contains the ANCOVA results and figure eight displays the outcome trend for disability in NR-CAT and SDR-CAT.

Table 6. ANCOVA and effect sizes (ES) for disability outcomes

Covariate	Dependent Variable	F value	Significance	ES (d)
WSAS Screening	WSAS (reform)	$F(2,23) = .000$	$p = .995$.000
	WSAS (post)	$F(2,23) = .524$	$p = .476$.302
	WSAS (f-u)	$F(2,21) = .386$	$p = .541$.271

Figure 8. Trend of sessional mean scores for WSAS for NR-CAT & SDR-CAT.



(2) Relative effects of NR-CAT and SDR-CAT

Outcome scores and associated effect sizes for both arms are displayed for treatment (assessment-termination) in table seven and contact (screening-follow-up) in table eight (see p.64). Both NR-CAT and SDR-CAT produced large effect sizes for depression and medium and large effect sizes for anxiety and disability (Cohen, 1998).

Rates of depression (PHQ9) improvement, recovery, stasis, deterioration and harm were calculated for NR-CAT and SDR-CAT. Participants lost to follow-up were excluded from these analyses (NR-CAT n=2, SDR-CAT n =2). Individual change scores were computed for all participants using treatment, and contact scores. The associated rates of improvement, recovery, stasis, deterioration and harm are reported in table nine. The recovery rate for treatment was 21.4% for NR-CAT (n=3) and 61.5% for SDR-CAT (n=8). Recovery rates for contact were 41.7% for NR-CAT (n=5) and 45.5% for SDR-CAT (n=7).

Table 9. Rates of recovery, improvement, stasis, deterioration & harm in SDR-CAT and NR-CAT.

	NR-CAT		SDR-CAT	
	Treatment (n =14)	Contact (n =12)	Treatment (n =13)	Contact (n =11)
Recovered	21.4% (n =3)	41.7% (n =5)	61.5% (n =8)	45.5% (n =5)
Improved	21.4% (n =3)	33.3% (n =4)	7.7% (n =1)	18.2% (n =2)
Stasis	57.1% (n =8)	25% (n =3)	7.7% (n =4)	36.4% (n =4)
Deteriorated	0	0	0	0
Harmed	0	0	0	0

Table 7. Treatment (assessment-termination) outcomes and effect sizes (ES) for NR-CAT & SDR-CAT.

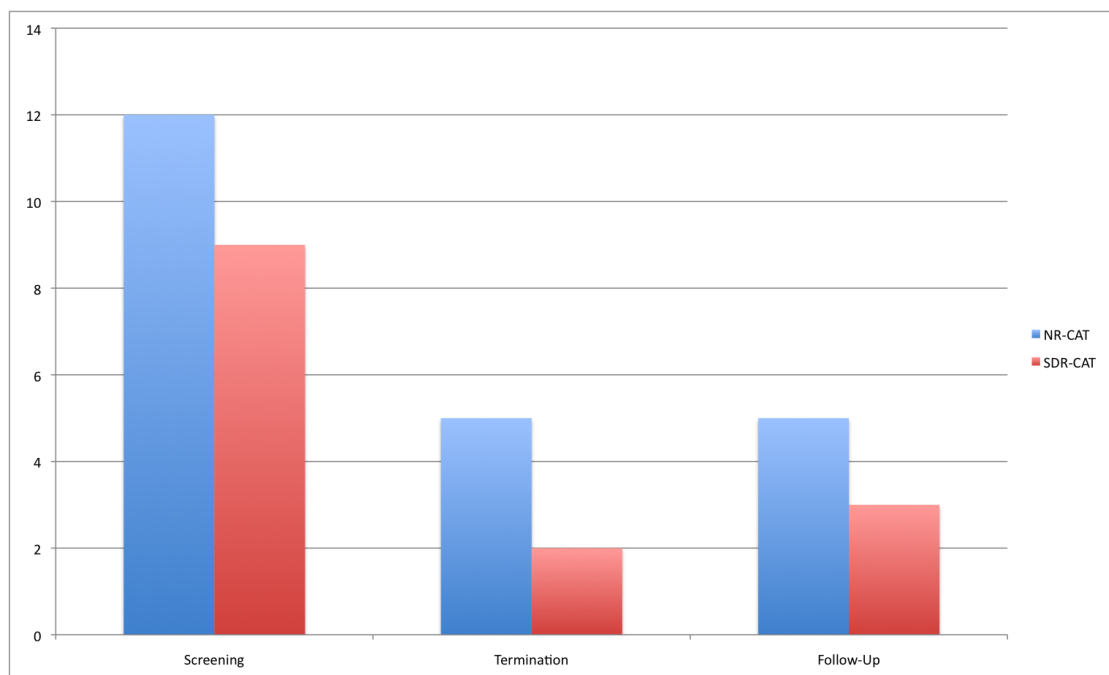
Arm	PHQ9			GAD7			WSAS		
	Pre Mean (SD)	Post Mean (SD)	ES (d)	Pre Mean (SD)	Post Mean (SD)	ES (d)	Pre Mean (SD)	Post Mean (SD)	ES (d)
NR-CAT	15.21(5.10) n=14	8.00(6.26) n=14	1.41	10.93(5.70) n=14	7.00(5.39) n=14	0.69	19.00(9.74) n=13	14.71(10.90) n=14	0.44
SDR-CAT	13.85(5.60) n=13	6.92(4.77) n=13	1.24	10.46(5.85) n=13	5.00(3.74) n=13	0.93	17.69(7.49) n=13	11.69(8.75) n=13	0.80

Table 8. Contact (screening-follow-up) outcomes and effect sizes (ES) for NR-CAT & SDR-CAT.

Arm	PHQ9			GAD7			WSAS		
	Screening Mean (SD)	Follow-up Mean (SD)	ES (d)	Screening Mean (SD)	Follow-up Mean (SD)	ES (d)	Screening Mean (SD)	Follow-up Mean (SD)	ES (d)
NR-CAT	15.21(5.10) n=14	8.64(8.01) n=14	1.28	10.93(5.70) n=14	7.31(6.86) n=13	0.64	19.00(9.74) n=13	14.15(11.82) n=13	0.50
SDR-CAT	13.85(5.60) n=13	6.58(5.19) n=12	1.30	10.46(5.85) n=13	4.50(4.21) n=12	1.02	17.69(7.49) n=13	11.25(8.30) n=12	0.86

With respect to clinical significance, at screening 85.7% (n=12) of the NR-CAT arm and 69.2%, (n=9) of the SDR-CAT arm met depression caseness criteria. At termination this reduced to 35.7% for NR-CAT (n=5) and 15.4% for SDR-CAT (n=2). These improvements were largely maintained at follow-up (see figure 9). In total, 21.4% (n=3) of the NR-CAT patients who met caseness criteria at screening achieved recovery at termination, for SDR-CAT this figure was 46.2% (n=6). At follow-up these rates were 25% (n =3) for NR-CAT, and 45.5% (n=5) for SDR-CAT. There were no significant differences in recovery rates between the arms at termination ($C^2(1, n =27) = .36, p = .415$) or follow-up ($C^2(1, n =23) = .03, p = .593$).

Figure 9. Number of patients meeting caseness on PHQ9 scores at screening, termination & follow-up for NR-CAT & SDR-CAT.



Helpfulness and the therapeutic alliance.

Sessional WAI ratings for both arms tended to improve incrementally as therapy progressed (see figure 10, p.67). There were no significant differences between groups on WAI scores at reformulation ($F(2,22) = .317$ $p = .579$; ES .240) or termination ($F(2,22) = .336$ $p = .568$; ES .247) when scores were adjusted using session one WAI scores as a covariate.

Within-group HAT ratings varied widely on a sessional basis (see figure 11, p.67). The SDR-CAT arm provided higher ratings for all but two sessions (higher scores represent increased helpfulness). However, there were no significant differences on HAT scores between the arms at reformulation when scores were adjusted using session one helpfulness scores as a covariate ($F(2,21) = 1.805$ $p = .193$; ES .587). There was a significant difference between the arms at termination ($F(2,21) = 5.270$ $p = .032$; ES 1.0) with the NR-CAT arm reporting the highest mean HAT scores (NR-CAT mean = 10.04, SD = 5.99; SDR-CAT mean = 6.091, SD = 6.80). Levene's test of equality of error variance was non-significant ($F(1, 22) = .036$, $p = .851$) indicating the ANCOVA assumption of homogeneity of variance was satisfied.

Figure 10. Graph displaying sessional mean scores on WAI for NR-CAT & SDR-CAT.

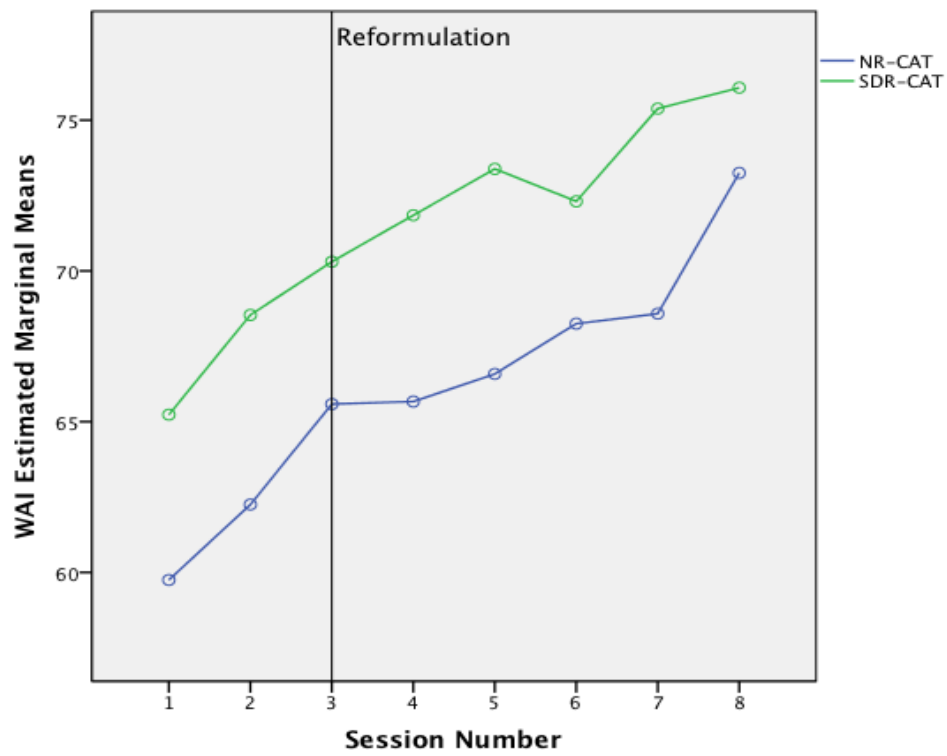
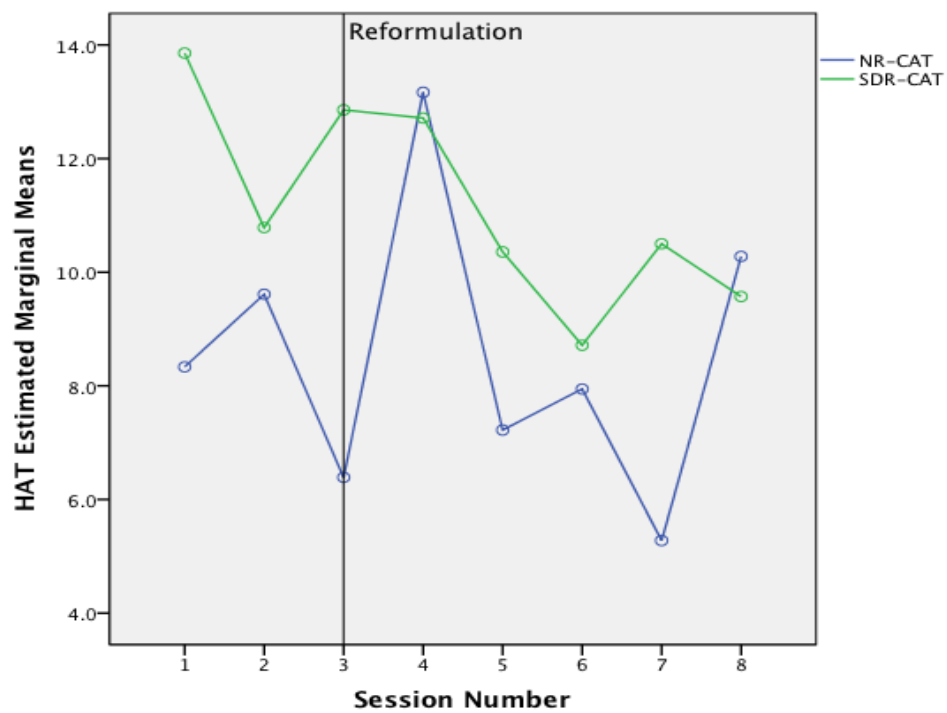


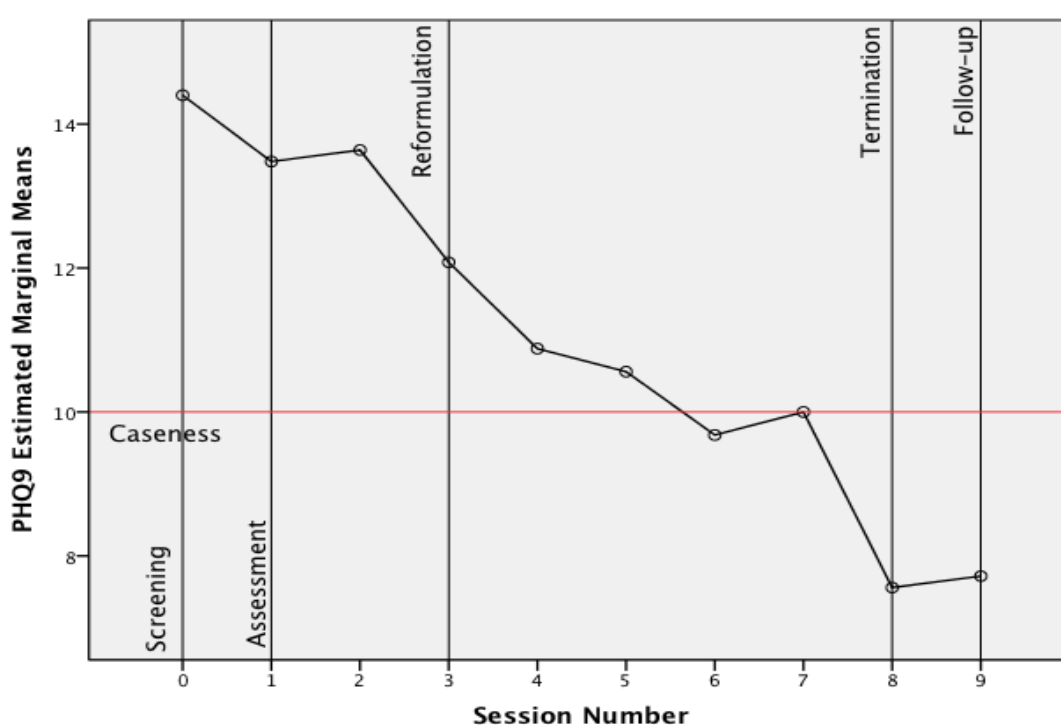
Figure 11. Graph displaying sessional mean scores on HAT for NR-CAT & SDR-CAT.



(4) The effectiveness of 8-session CAT for depression

Data from both arms was combined to identify the overall effectiveness of CAT. The severity of depression over time is displayed in figure 12. Paired sample T-Tests were used to look for differences at key time points (screening, assessment, reformulation, termination, and follow-up).

Figure 12. Graph displaying sessional mean scores on PHQ9 for full sample.



Depression

Highly significant differences were found between PHQ9 scores at screening and all subsequent time point interactions (reformulation, termination and follow-up; see table 10, p. 69). Significant reductions in depression occurred between screening and ⁽¹⁾ reformulation ($t(26) = 2.86, p = .004, ES 1.14$), ⁽²⁾ termination ($t(26) = 6.037, p = .000, ES 2.42$), and ⁽³⁾ follow-up ($t(25) = 6.065, p = .000, ES 2.48$). Depression also significantly reduced between assessment and ⁽¹⁾

reformulation ($t(26) = 1.85, p = .038, ES 0.74$), ⁽²⁾ termination ($t(26) = 5.698, p = .000, ES 2.28$), and ⁽³⁾ follow-up ($t(25) = 6.250, p = .000, ES 2.55$). Large effect sizes were evident for all pre-post analyses.

Table 10. Session comparisons of PHQ9 data for full sample.

Session comparison	Mean (SD)	df	t	Sig. (one tailed)	ES(d)
Screening - Reformulation	2.44(4.44)	26	2.860	.004	1.14
Screening - Termination	7.07(6.09)	26	6.037	.000	2.42
Screening - Follow-up	6.50(5.46)	25	6.065	.000	2.48
Assessment - Reformulation	1.44(4.06)	26	1.848	.038	0.74
Assessment - Termination	6.07(5.54)	26	5.698	.000	2.28
Assessment - Follow-up	5.538(4.519)	25	6.250	.000	2.55

Recovery rate analysis

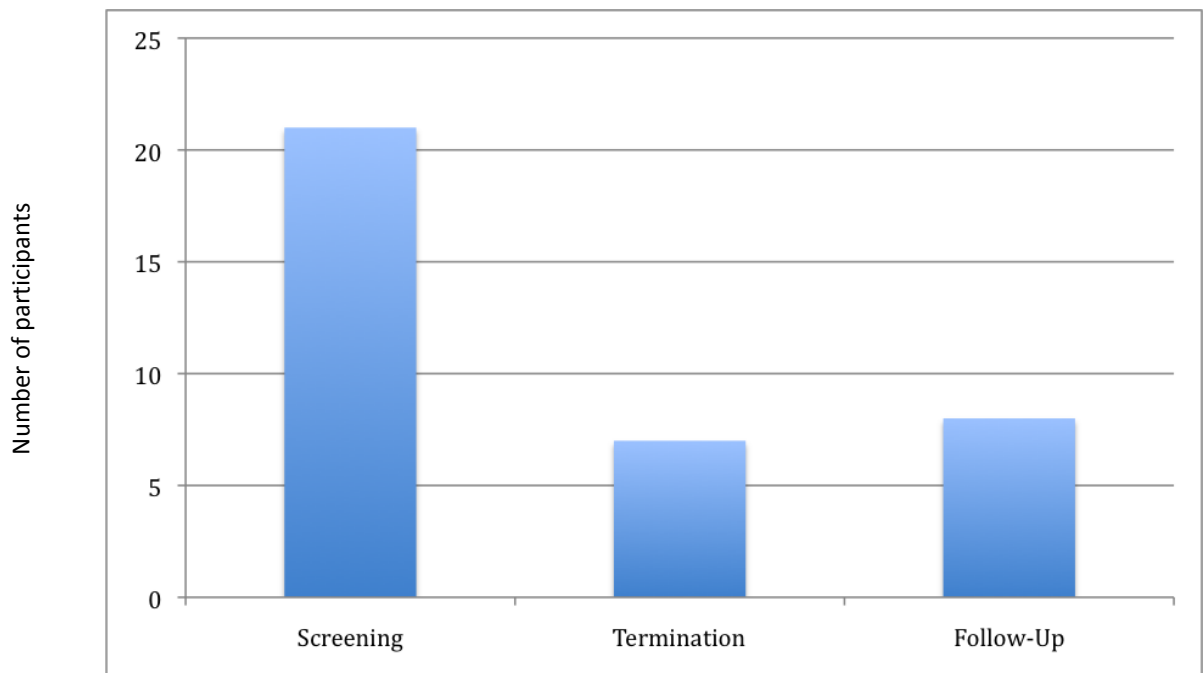
Table eleven shows the recovery rate analysis for the full sample. The recovery rates were 40.7% (n= 11) for treatment and 43.5% (n=10) for contact. The RCI identified 55.56% (n=15) of patients achieving a reliable reduction in depression in the treatment phase, which increased to 69.57% (n= 16) across the contact phase. Participants lost to follow-up were excluded from the analysis, n=4.

With respect to clinical significance, 77.77% (n=21) of the full sample met caseness (PHQ9 score >10) at screening, 25.93% (n=7) at termination, and 34.78% (n=8) at follow-up (see figure 13, p. 70). Of the initial 77.77% of patients meeting caseness criteria at screening, 55.6% (n=15) had moved out of the clinical range at termination, this figure was 43.5% (n =10) at follow-up.

Table 11. Rates of recovery, improvement, stasis, deterioration & harm in the full sample.

	Full sample CAT	
	Treatment (n =27)	Contact (n =23)
Recovered	40.7% (n =11)	43.5% (n =10)
Improved	14.8% (n =4)	26.1% (n =6)
Stasis	44.4% (n =12)	30.4% (n =7)
Deteriorated	0	0
Harmed	0	0

Figure 13. Number of patients meeting caseness on PHQ9 scores at screening, termination & follow-up in the full sample.



Helpfulness and the therapeutic alliance.

Sessional WAI ratings for the full sample tended to improve incrementally as therapy progressed (see figure 14, p.72) with the highest mean scores achieved at termination. HAT ratings suggest earlier sessions tended to be more helpful than later ones, with the highest mean ratings at session four (see figure 15, p. 72). However, mean session ratings remained within a fairly small range (7.5 -13.0). Content analysis (Hsieh & Shannon, 2005) was used to explore perceptions of the most helpful aspects of therapy. This identified themes of (1) CAT tools, (2) CAT techniques, and (3) nonspecific therapeutic elements. These are displayed in figure sixteen (p. 73) with frequency counts for identified components.

Figure 14. Sessional mean scores on WAI for full sample.

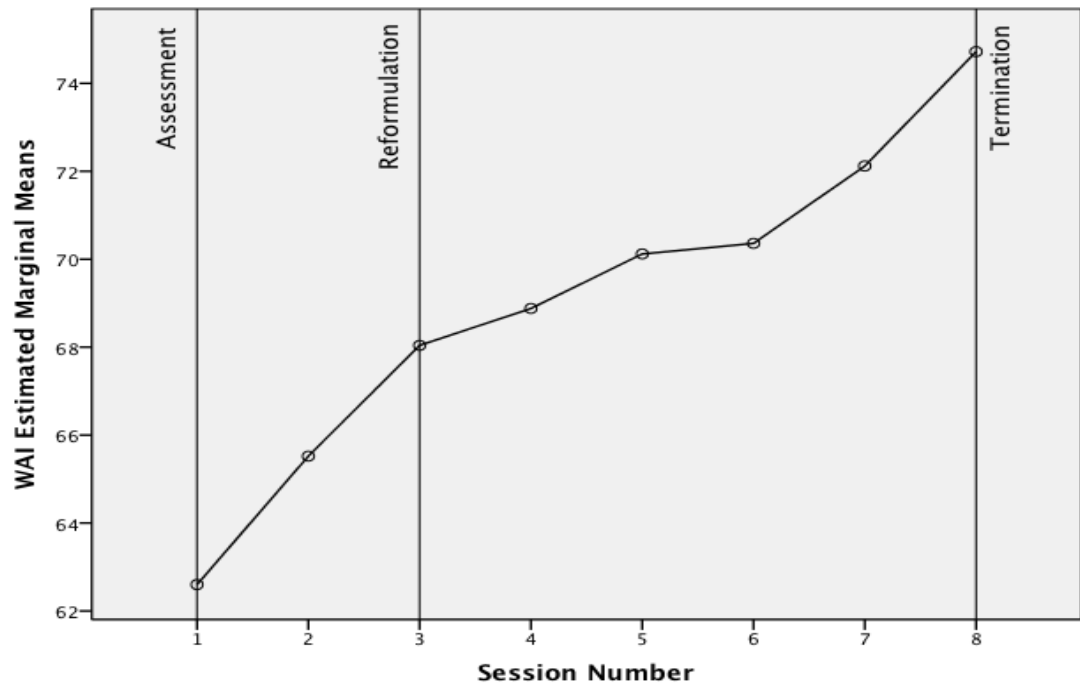


Figure 15. Sessional mean ratings on HAT for full sample.

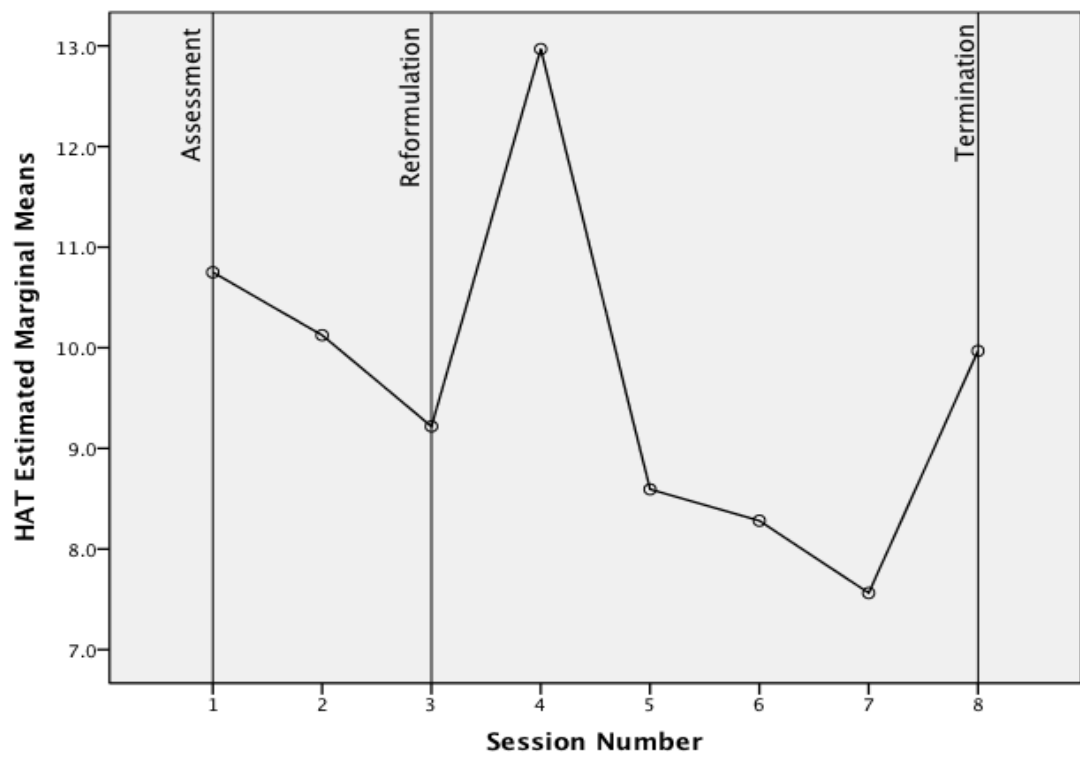
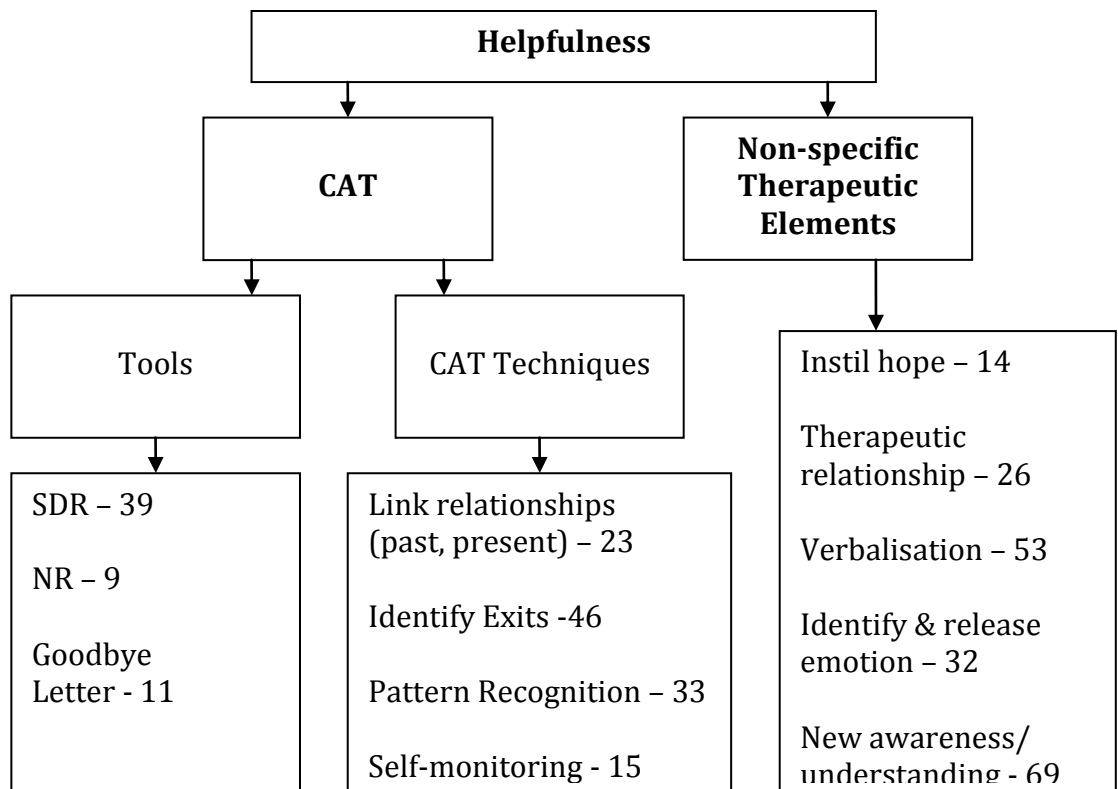


Figure 16. Content analysis of qualitative data from HAT for full sample.



In relation to CAT tools, the most frequently noted helpful aspect was the use of mapping techniques in the production of the SDR, and its subsequent application throughout therapy. Participants also noted the NR and goodbye letter as helpful. CAT techniques that were frequently cited included the identification of exits on the SDR and improved pattern recognition. Participants also acknowledged the helpfulness of making links between past and current relationships and associated self-monitoring techniques. A number of non-specific therapeutic elements were identified as helpful, most prevalent was gaining a new awareness or understanding (e.g. of ones self or ones problems), and the opportunity to verbalise difficulties. The identification and release of emotions, quality of the therapeutic relationship (e.g. collaborative, understanding, listening, encouraging), and ability of the therapy/therapist to instil hope were also often stated.

Discussion

This study investigated the efficacy of NR for depression in CAT by comparing patients receiving standard CAT with patients receiving CAT without NR. This was achieved via a deconstruction trial methodology. No previous CAT deconstruction trials have been completed and only six depression component analyses have been conducted (see Ahn & Wampold, 2007; Longmore & Worrell, 2007). The results provide no support for NR enhancing the clinical efficacy of CAT, the working alliance, or perceived helpfulness of therapy. Clients receiving NR did not achieve better outcomes (greater symptom amelioration) in comparison to clients randomised to CAT without NR therefore hypothesis one was rejected. Clients receiving NR did not report enhanced therapeutic alliances in comparison to clients randomised to CAT without NR and hypothesis two was rejected. Finally, clients receiving NR did not perceive CAT as more helpful in comparison to clients randomised to CAT without NR so hypothesis three was rejected.

Both arms achieved equal outcomes at reformulation, termination and follow-up after adjusting for scores at screening. No differences were identified regarding patient ratings of the therapeutic alliance or perceived helpfulness of therapy between the two arms after adjusting for scores at the start of CAT (assessment). Participants in both arms tended to follow an incremental pattern of improvement as therapy progressed. Ratings of helpfulness displayed greater within-group variability, patients in the SDR-CAT arm tended to return higher mean scores, but not significantly so. The exception to this was session eight (termination), when the NR patients reported significantly higher ratings of helpfulness. Rates of reliable and clinically significant change in both arms were

comparable and high throughout. No deterioration or harm was evident in either arm, providing evidence of brief CAT for depression being a 'safe' approach.

This research also indexed the effectiveness of 8-session CAT for depression by combining data from both arms and conducting pre-post comparisons. There were significant reductions in depressive symptomology between pre-therapy (screening, assessment), reformulation, and post-therapy (termination, follow-up) scores. Significant reductions were achieved between pre-therapy and reformulation, highlighting the effectiveness of CAT at alleviating the symptoms of depression early in therapy. Kellett, Bennett, Ryle and Thake (in press) have also noted the utility of CAT in early sessions and attributed this to the high activity of CAT therapists regarding reformulation. Highly significant differences were found in pre-post analyses, attesting to the effectiveness of CAT for significantly reducing patients' depressive symptomology over an 8-session intervention. Gains were maintained at the 8-week follow-up indexing short-term durability. Large effect sizes were evident for all pre-post comparisons (Cohen, 1988) indicating clinical effectiveness, with effect sizes comparable to those reported in a recent review of patient outcomes in IAPT services (Clark et al., 2009).

Concerning the working alliance, patient ratings in the full sample demonstrated progressive improvement as therapy advanced, with the highest ratings of working alliance being achieved at termination. This ability of CAT to facilitate positive working relationships is important, as the working alliance is considered critical for success in psychotherapy in general (Hovarth, Del Re, Fluckiger & Symonds, 2011). Prior research with patients with a diagnosis of depression has identified a relationship between patients' expectations of

improvement, treatment outcomes and the working alliance (Gaudiano & Miller, 2006; Webb et al., 2012). The working alliance has also been shown to reliably predict treatment outcomes across modalities (Martin, Garske & Davis, 2000; Webb et al., 2011), and specifically in short-term psychotherapy (Joyce, Ogrodniczuk, Piper & McCallum, 2003; Gullo, Lo Coco & Gelos, 2012). When therapeutic interventions meet patient expectations, patients' collaboration and trust in the therapeutic process increases (Joyce et al., 2003). The increase in alliance scores over time in the current study therefore suggest CAT interventions met patient expectations, enabling positive alliances to form early in therapy which then improve as therapy progresses due to the collaborative stance advocated by CAT (Ryle & Kerr, 2002). This suggests the ability of CAT to create positive working alliances early in therapy is likely to have contributed to its overall effectiveness. In the current study, reformulation (either NR or SDR) occurred early and may have created this effect.

In terms of the helpfulness of therapy, scores in the full sample suggest earlier sessions tended to be perceived as more helpful than later ones. Ratings progressively decreased over time with the exceptions of sessions four and eight. For session four, this was mostly due to the high ratings from patients in the NR arm, who received the SDR at session four. It is notable that a similar peak in scores was not evident for the introduction of the SDR for patients who didn't receive NR. However, with the exception of initial HAT ratings in the SDR-CAT arm, scores for the session when the SDR was introduced were the highest overall. This supports the role of the SDR as a critical component of CAT (Ryle & Kerr, 2002). Interestingly, despite a number of patients in the NR-CAT arm identifying the NR as helpful, the reformulation session achieved the second lowest rating for

helpfulness. NR may have aroused negative affective experiences (e.g. Hamill et al., 2008) and so may have impacted on the helpfulness of the session. Research suggests that sessions with a high emotional content can be experienced as 'rough' and 'uncomfortable' by patients (Reynolds, Stiles, Barkham, Shapiro, Hardy & Rees, 1996) and this may have impacted on post-session helpfulness ratings. The increased helpfulness ratings at termination appear to be associated with the goodbye letter, 47.8% of patients specifically attributed these scores to the goodbye letter. This provides support for the contribution of goodbye letters to patient management of endings, consistent with the literature on therapeutic letters (Howlett & Guthrie, 2001; Freed et al., 2010; Ryle & Kerr, 2002).

Despite the failure of NR to enhance therapeutic outcomes or processes as theoretically implicated, 69.2% (n=9) of patients in the present study receiving a NR rated it as helpful. This is consistent with qualitative research that identifies significant subjective impact of NR on feelings of intra and interpersonal connectedness (Hamill et al., 2008), the structure and professionalism of CAT and the initiation of change processes (Rayner et al., 2011). Further disparity is apparent from studies which evidence 'sudden gains' in target symptoms immediately following the introduction of NR in Personality Disorder (e.g. suspiciousness, Kellett, 2005; dissociation, Kellett, 2012). This suggests that some patients may benefit from NR and this area may benefit from further consideration. It is possible that the impact of NR is greater when difficulties in interpersonal functioning are significant or problems are complex and entrenched (e.g Ryle & Beard, 1993). However, in brief 8-session CAT with Axis I disorders, then the effect of NR appears negligible and clinical time therefore potentially can be saved by removing this task.

Overall, the results suggest that 8-session CAT is an effective treatment for depression. Significant symptomatic improvement was observed across the assessment and reformulation phases and patients continued to improve as therapy progressed. Gains obtained by the end of therapy were maintained at follow-up and treatment outcomes are comparable to other therapeutic modalities commonly employed in Primary Care/IAPT services. The NR was not however identified as enhancing the efficacy of CAT, improving therapeutic alliances or increasing the helpfulness of sessions.

Post-reformulation the primary aim of CAT is to enable the patient to recognise and revise previously unrecognised maladaptive (self-limiting or self-harming) procedures (Birthchnell, Denman & Okhai, 2004; Denman, 2001). Recognition of these procedural enactments allows for opportunities to practice alternative responses and therefore identify potential exits. Ryle (1994) suggests the SDR offers an alternative and frequently 'more powerful representation' of these target problem procedures (TPPs) in comparison to NR, succinctly summarising the core states and procedural sequences available to the client. This appears consistent with patients' subjective experiences in the present study, wherein the identification of exits on the SDR and improved pattern recognition were frequently cited as helpful. Both of these actions (exit identification and pattern recognition) can be directly related to the applications of the SDR post-reformulation, confirming its central role in CAT (Ryle & Kerr, 2002).

Procedural sequences represented on the SDR incorporate multiple psychoemotional and interpersonal features. These include cognitive, motivational, behavioural and affective elements (Denman, 2001). Component studies finding equivalence for separate aspects of treatment, such as the cognitive

and behavioural elements of CBT (Jacobson et al., 1991), suggest that therapeutic impact in one area can then initiate a change process that ultimately produces widespread change (Jacobson et al., 1991). By offering a multimodal representation of TPPs, CAT offers multiple intervention opportunities (Kellett, 2012). Theoretically, CAT proposes that specific exits developed during the final revision stage elicit change by positively impacting on one element of an underlying maladaptive procedure by short-circuiting its subsequent reinforcement (Denman, 2001). This may explain why component analysis studies consistently fail to identify model-specific features underlying clinical change processes (Ahn & Wampold, 2001).

Theoretical and Clinical Implications

The inability of this research to identify enhanced efficacy associated with NR in CAT is consistent with existing research, which persistently fails to demonstrate the mediating effects of specific components of psychotherapies (Ahn & Wampold, 2001). The finding that CAT employing the SDR alone is equal in efficacy to complete CAT (NR plus SDR) runs counter to the theoretical importance of NR (Ryle, 1994) and extant qualitative evidence attesting to NRs ability to augment the therapeutic alliance and patient functioning (Hamill et al. 2008; Rayner et al., 2011). The study findings therefore have marked clinical and theoretical implications for the practice of CAT with depression.

Clinically, it brings into question whether NR is necessary to produce therapeutic benefits in depression. Without demonstrable clinical efficacy, the valuable clinical time spent producing and sharing NR (e.g. Howlett & Guthrie,

2001) may be better spent collaboratively constructing the SDR. The failure of NR to improve outcomes in the current study, suggests SDR alone may be more clinically efficient. Similarly, if NR does not enhance clinical outcomes but does have the potential to invoke negative affect states (Hamill et al., 2008; Rayner et al., 2011; Evans & Parry, 1996), then its continued use may not be therapeutically indicated.

Regarding the potential utility of brief CAT for depression in Primary Care it seems appropriate to consider the effectiveness of the intervention in terms of current IAPT service targets. IAPT services with the best recovery rates provide on average 8-10 therapy sessions (Gyani, Shafran, Layard & Clark, 2011) and offer therefore a similar therapeutic dosage to the current study. The present study contributes to our understanding of the minimum number of sessions required for sufficient improvement, which is poorly evidenced in CAT (Birtchnell, Denman & Okhai, 2004) and is in line with the dose-effect literature (Barkham, Rees, Stiles, Hardy, Shapiro, 2002). Reviewing the effectiveness of various therapeutic doses with respect to patient outcomes, recovery, clinical change and relapse rates for depression and other common mental health problems would have great clinical validity for the CAT evidence base.

In terms of therapeutic benefits, the recovery target within IAPT services is set at 50% of patients moving 'towards recovery' (Clark et al., 2009). The 8-session CAT intervention achieved good recovery rates (48.1%). This figure represents only those patients who were considered clinically recovered at termination. With respect to those moving 'towards recovery', IAPT services recently reported 64% of all patients (multiple diagnoses, not exclusively depression) showing reliable improvement, 29% in stasis, and 7% experiencing a reliable deterioration (Gyani,

Shafran, Layard & Clark, 2011). In the current study, screening to follow-up analyses identified reliable improvement for 69% of patients, stasis for 26% and no patients displayed reliable deterioration or harm. This comparison again suggests CAT as a safe treatment for depression.

The study results are promising in light of the relatively brief session contract and also use of non-CAT trained therapists. Further studies of the efficacy of brief CAT for other common mental health problems are sorely needed (Simmonds & Kellett, 2012). The percentage of patients completing therapy after attending at least one session was very high (88.9%). This is comparable to CAT research in general psychotherapy services where completion rates are reported at 82% (Dunn, Golyunkina, Ryle & Watson, 1997) and 90% (Kellett et al., in press). The 11% non-completion rate found in the current study is below the 34% rate reported for IAPT (Clark et al., 2009).

These rates suggest brief CAT is a highly palatable treatment for patients displaying symptoms of depression. Research suggests that patients who complete therapy are more likely to achieve clinically significant change (Cahill et al., 2003), so low drop out is an important consideration in terms of service governance. The clinical outcomes achieved in this study also contribute to the evidence that trainee practitioners are able to deliver CAT with sufficient proficiency under suitable supervision. Existing research has identified significant clinical improvements for patients treated by trainee psychiatrists delivering CAT under satisfactory supervision conditions (Mace, Beeken & Embleton, 2006). Collectively these results suggest CAT is a relatively user-friendly and accessible model for trainee therapists. The accessibility of CAT for both patients and therapists may have contributed to its widespread application and dissemination (Margison,

2000). Empirical validations of the efficacy and effectiveness of CAT are now required to meet the demands of an increasingly evidence-led approach to clinical guidance and commissioning of services (Simmonds & Kellett, 2012). The present study contributes to the practice-based evidence (Barkham et al., 2001) for CAT with depression, providing initial evidence of its effectiveness in clinical practice. This enhances the clinical validity of the findings (Puschner, Kraft, Kachele & Kordy, 2007) and contributes to the developing CAT effectiveness literature (e.g. Marriott & Kellett, 2009; Dunn, Golyunkina, Ryle & Watson, 1997). However, participants in this research were still subject to a number of exclusion criteria, potentially limiting the range of difficulties that may present in routine clinical practice. This should be acknowledged when considering the applicability and suitability of brief CAT in Primary Care.

Methodological Critique

A key critique of the present study is the sample size. Caution should be exercised when drawing conclusions from such a small sample, which may have been insufficiently powered to identify statistically significant differences between the two treatment arms (Bower & Gilbody, 2005). This is potentially exacerbated by the small effect sizes produced in the between-groups comparisons. Despite this, component analyses are acknowledged as having the potential to draw stronger causal conclusions (Czaja, Schultz, Lee & Belle, 2003) and this research is unique in attempting to isolate the efficacy of NR in CAT.

Identifying the active ingredients of therapy is a complex and multifaceted endeavour with the potential for numerous additional factors to impact on

treatment, such as therapist effects (Hotopf, 2002). Whilst these cannot be eradicated, this study has good external validity due to its focus on CAT delivered in routine clinical practice (Green, 2006). The addition of process measures arguably increases the ecological validity of the research (Green, 2006).

This research employed a deconstruction trial methodology, which is considered the 'gold standard' (Ahn & Wampold, 2001) in elucidating the impact of specific therapeutic ingredients. The control condition was standard CAT (treatment as usual), which is arguably the best control condition (Green, 2006). Despite this some differences between the arms were unavoidable. Isolating the efficacy of the NR whilst holding all other aspects constant meant patients receiving NR and SDR had two reformulation and four exit-focussed sessions. Patients in the SDR-CAT arm had one reformulation and five exit-focussed sessions. In such a brief therapy, this difference may be critical, particularly as the helpfulness of exit formation was frequently cited by participants.

The follow-up period of 8 weeks in this study was somewhat brief, particularly given the potential relapsing nature of depression where residual symptoms remain post-therapy (Scogin, Hanson & Welsh, 2003). Existing research does suggest that patients are able to maintain the gains made from CAT. For example, Birtchnell, Denman & Okhai (2004) identified treatment durability for CAT outcomes in general clinical populations at a three-month follow-up, and Tzouramanis et al., (2010) reported that improvements at eight-week follow-ups were maintained twelve months post-therapy following CAT for panic disorder. A significant proportion of the latter study sample (32%) displayed co-morbid depressive disorders or additional Axis II diagnoses (58%, e.g. avoidant personality disorder) and so displayed higher levels of disability than the present

study. A longer-term review of the sustainability of improvements (i.e. treatment durability) following brief CAT for depression (including relapse rates) would be useful.

The therapists in this research were not qualified CAT practitioners, which potentially impacted on model adherence and competence. There is a possibility that the lack of efficacy for the NR represents a type III error, whereby an intervention is deemed ineffective when it has not been implemented as intended (Kovach, Cashin & Sauer, 2006). The regular auditing of tapes in supervision was a check on sufficient model fidelity. However, the non-expert nature of the therapists in the present study suggests the results obtained are conservative and may be enhanced if experienced CAT therapists delivered the therapy.

Recommendations for future research

Further research into the clinical effectiveness and efficacy of CAT with depression and other common mental health problems is strongly recommended (Simmonds & Kellett, 2012). Future research should seek to address this concern by further investigating the applicability, suitability and effectiveness of brief CAT in Primary Care for common mental health problems. Additional consideration of other diagnostic categories with respect to the efficacy of NR will further address discordant findings of NR as a significant therapeutic event (Hamill et al., 2008, Rayner et al., 2011) and the lack of any quantifiable outcomes identified by outcome research (Shine & Westacott, 2010; Evans & Parry, 1996). Future research should also seek to use trained CAT therapists and measures of clinical competence in CAT (CCAT; Bennett & Parry, 2004) to ensure satisfactory treatment adherence.

The efficacy of CAT has been poorly addressed in comparison to other psychotherapeutic approaches (Cuijpers et al. 2008). Research using larger sample sizes with controlled and truly longitudinal methodologies could enhance the evidence base, clarify the clinical validity of CAT and begin to address the uptake versus credibility dilemma (Marriott & Kellett, 2009). Longitudinal approaches have particular clinical significance for depressive disorders with chronic and relapsing features (Cuijpers et al. 2008). Recent clinical guidance identifies a suitable research follow-up period of at least 18 months for CAT with BPD (NICE, 2009). This would provide a good basis for reviewing the durability of clinical outcomes across diagnoses.

Conclusions

This study found no evidence to suggest NR in CAT for depression enhances clinical efficacy with respect to patient outcomes, the working alliance or perceived helpfulness of therapy. Therapeutic outcomes in NR-CAT and SDR-CAT displayed equivalent efficacy at reformulation, termination and follow-up across outcome measures. Rates of reliable and clinically significant change, deterioration and harm were comparable throughout across NR-CAT and SDR-CAT.

This effectiveness of 8-session CAT for depression was investigated using pre-post comparisons on PHQ9 scores by combining outcomes in both arms. Significant reductions in depressive symptomology were achieved between assessment and reformulation, and highly significant differences and large effect sizes were evident on all pre-post comparisons. CAT was effective at alleviating the symptoms of depression early in therapy and significantly reducing depressive symptomology over treatment, with improvements maintained at follow-up. Working alliance ratings demonstrated progressive improvement over time, peaking at termination. Earlier therapy sessions tended to be more helpful than later ones. Ratings for the SDR session were highest overall, with the NR session achieving the second lowest rating for helpfulness.

Overall, results suggest 8-session CAT is an effective treatment for depression. Significant symptomatic improvement was observed across therapy and follow-up. Treatment outcomes are comparable to other therapeutic modalities commonly employed in IAPT. The NR did not enhance the efficacy of this outcome however, with results supporting the importance of the SDR in CAT.

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Appendix i



National Research Ethics Service

Trent Research Ethics Committee

Research Ethics Office
The Old Chapel
Royal Standard Court
Nottingham
NG1 6FS

Telephone: 0115 8839436
Facsimile: 0115 9123300

14 September 2010

Miss Clair Stockton
Trainee Clinical Psychologist
Sheffield Health and Social Care
Clinical Psychology Unit
University of Sheffield
Western Bank
S10 2TN

Dear Miss Stockton

Study Title: The Impact of Reformulation in the Treatment of Mild-Moderate Depression with Cognitive Analytic Therapy; a controlled study
REC reference number: 10/H0405/53

Thank you for your letter of 14 September 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

The Committee has not yet been notified of the outcome of any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. I will write to you again as soon as one Research Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures should be initiated at non-NHS sites.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the
National Patient Safety Agency and Research Ethics Committees in England

WPH 1370

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Investigator CV		09 July 2010
Protocol	VII	25 August 2010
Research Proposal Costing Form		09 November 2009
REC application		09 July 2010
Covering Letter		09 July 2010
Questionnaire: PHQ9		
GP/Consultant Information Sheets	IV	17 May 2010
Participant Information Sheet	VI	31 August 2010
Response to Request for Further Information		25 August 2010
Response to Request for Further Information		14 September 2010
Participant Consent Form	IV	17 May 2010
Questionnaire: WA1-S		
Questionnaire: HAT		
Questionnaire: CCAT		
CV for Dr Stephen Kellett		08 July 2010
Letter from University of Sheffield		28 June 2010
Evidence of insurance or indemnity		20 July 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0405/53

Please quote this number on all correspondence

Yours sincerely

PP 

Mr Peter Korczak
Chair

Email: carol.marten@nottspct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mr Micheal Bramall
Barnsley NHS Trust
Research and Governance Office, Block 14
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Gawber Road, Barnsley S75 2EP

Dr Steve Kellett
Clinical Psychology Unit
The University of Sheffield
Western Bank S10 2TN

Your Ref:

Our Ref: SB/AS/ResGov/22Jul10/05

Longfields Court
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Please ask for: Sue Bentley

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20 September 2010

Website: www.barnsleypct.nhs.uk

Miss Clair Stockton
Sheffield Health and Social Care
Clinical Psychology Unit
University of Sheffield
Western Bank
S10 2TN

Dear Miss Stockton

The Impact of Reformulation in the Treatment of Mild-Moderate Depression with Cognitive Analytic Therapy; a controlled study.

Thank you for submitting the above project. The project was considered by the Research Governance Committee of Barnsley Health and Social Care Research and Development Alliance at a meeting and I am pleased to confirm that the committee agreed to approve the project.

In acting as Principal Investigator for Barnsley on this project, you must make yourself familiar with, observe and comply with:

- The informed consent and procedures approved by the Ethics Committee.
- The Department of Health Research Governance Framework and conduct your research in accordance with its principles.
- The Trust's Health and Safety policy.
- The Trust's procedure for the recording and reporting of adverse incident. In the event of an adverse incident the Ethics Committee and Research Governance Office must also be notified.
- The Trust's Equal Opportunities policy.
- The Trust's Information Security and Confidentiality policy.
- The Trust's Financial Regulations and procedures, if applicable.

You must also:

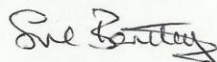
- Immediately notify the Ethics Committee and the Research Governance Office of any changes in protocol or new information that would raise questions about the continued conduct of the research.
- Ensure that all data and documentation is available for auditing purposes.

Miss Clair Stockton
Sheffield Health and Social Care.....

Basic information on the project will be entered into the Trust's research database and may be submitted to the National Research Register. The research office may seek further information from time to time in order to fulfil the information requirements of the Trust or NHS Executive.

I should be grateful if you could provide a brief annual report on the progress of the research to the Research Office, including reference to any publications that have arisen from the research. This report should be submitted during March each year, so that pertinent information can be included in the Trust's Annual Research Report.

Yours sincerely



Sue Bentley
Director of Performance and Governance

Cc: Research Governance Office, BHNFT



With all of us in mind

South West Yorkshire Partnership **NHS**
NHS Foundation Trust

9th January 2012

Miss Clair Stockton
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Ref: Re-issued APPROVAL Letter
Email address: helen.carter@swyt.nhs.uk

Dear Miss Stockton

Re: The Impact of Reformulation in the Treatment of Mild-Moderate Depression with Cognitive Analytic Therapy: A Controlled Study

REC Reference: 10/H0405/53

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and NHS Permission has been granted on behalf of Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within **South West Yorkshire NHS Foundation Trust**.

The final list of documents reviewed and approved is as follows:

Document	Version	Date
Investigator CV		09 July 2010
Protocol	VII	25 August 2010
Research Proposal Costing Form		09 November 2009
REC Application		09 July 2010
Covering Letter		09 July 2010
Questionnaire: PHQ9		
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Questionnaire: CCAT		
CV for Dr Stephen Kellett		08 July 2010
Letter from University of Sheffield		28 June 2010
Evidence of Insurance or Indemnity		20 July 2010

Chair: Joyce Catterick OBE Chief Executive: Steven Michael

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Appendix ii



Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

**Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP UK**

Telephone: 0114 2226570
Fax: 0114 2226610
Email: dclipsy@sheffield.ac.uk
Please address any correspondence to Ms. Christie
Harrison, Research Support Officer

Research Governance Office

28th June 2010

Dear Sir/Madam,

RE: Project title: The impact of reformulation in the treatment of mild-moderate depression
with cognitive analytic therapy
Applicant: Clair Stockton (DClin Psy Trainee)

- 1. Confirmation of NHS employment status**
- 2. Confirmation of independent scientific approval**
- 3. Confirmation of Indemnity of enclosed Research Project**

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield and that the applicant is under pressure to complete this within a designated time period.

I also confirm that the applicant, Clair Stockton, is an NHS employee and is also supervised by a clinical academic. As such the applicant has an NHS contract and has had a CRB check.

Three independent reviewers appointed by the Clinical Psychology Unit Research Sub-committee have scientifically reviewed it, including an external academic and statistician.

I can confirm that all necessary amendments have been made to the satisfaction of the reviewers, who are now happy that the proposed study is of sound scientific quality. Consequently, the University will also indemnify it, and would be happy to act as research sponsor once ethical approval has been gained.

Given the above, and in line with current NHS guidance I would ask that you exempt this proposal from further NHS scientific review and the applicant from completing an unnecessary honorary contract. The Unit already has an agreement with several local NHS Trusts (SHSRC, STH & SCH) to this effect. If you require any further information, please do not hesitate to contact me.

Yours faithfully



Dr. Andrew Thompson
Director of Research Training
Senior Clinical Lecturer & Chartered Clinical/Health Psychologist

Cc. Clair Stockton, Dr Stephen Kellett (supervisor)

Appendix iii

PHQ- 9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not all	at Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

A11 – PHQ9 total score

Appendix iv

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

A12 – GAD7 total score

Appendix v

Work and Social Adjustment

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable)

0	1	2	3	4	5	6	7	8	N/A
Not at all		Slightly		Definitely		Markedly	Very severely,		<input type="checkbox"/>
							I cannot work		

2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

3. **SOCIAL LEISURE ACTIVITIES** - With other people, e.g. parties, pubs, outings, entertaining etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

4. **PRIVATE LEISURE ACTIVITIES** – Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

5. **FAMILY AND RELATIONSHIPS** – Form and maintain close relationships with others including the people that I live with

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

A13 – W&SAS total score

Appendix vi

Working Alliance Inventory (removed for copyright purposes)

Appendix vii

Helpful Aspects of Therapy (removed for copyright purposes)

Appendix viii



Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training
& consultancy.

**Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TN UK**

Project title: Psychotherapy Research

1. I confirm that I have read and understood the information sheet for the above research and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I understand that my responses will be anonymised before analysis. I give permission for members of the research team to have access to my anonymised responses. ☐
4. I understand that anonymised data from the above research project will be submitted as part of a Doctor of Clinical Psychology training programme, which may result in its publication in a medical journal. ☐
5. I agree for therapy sessions to be audio taped. ☐
6. I agree to take part in the above research project. ☐

Name of participant
Date
Signature

Name of person taking consent	Date	Signature
<i>To be signed and dated in presence of the participant</i>		

_____ Lead Researcher	_____ Date	_____ Signature
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Copies provided for:

Participant	<input type="checkbox"/>	Site File	<input type="checkbox"/>	Patient File	<input type="checkbox"/>
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Participant Identification number: _____

Appendix ix



Patient Information Sheet

The Impact of Reformulation in the Treatment of Mild-Moderate Depression with Cognitive Analytic Therapy; a controlled pilot study

This information sheet is to help you to decide if you would like to take part in a research study. It will help you understand why this research is important, why you have been invited to take part, and what you will be asked to do. After you have read the sheet please feel free to ask any questions. Talking with friends, family or your GP may help you to decide.

What is the research?

This research looks at how we provide therapy for people with depression or low mood. We hope to find out how specific parts of therapy affect your progress in treatment.

Why is this important?

Finding out which parts of therapy are the most helpful to patients could help us to make the treatment you receive more effective. Sometimes we don't know which way of treating patients is best. To find out, we need to compare treatments. We put people into groups and give each group a slightly different treatment. The results are compared to see if one is better. To try to make sure the groups are the same to start with, each patient is put into a group by chance (randomly).

How will you do this?

Patients who agree to take part will be randomly placed in one of two groups with slightly different types of treatment. We will offer everyone 8 sessions of therapy with a 'follow up' session around 8 weeks later.

After each session we will ask you to fill in a questionnaire about how you are feeling (your symptoms), and how helpful the session was for you. Looking closely at therapy in this way helps us to see which parts are most useful. It will also help your therapist to know more about how you are finding therapy.

Who provides the therapy?

The therapy will be provided by one of three trainee clinical psychologists in their third and final year of doctoral training. A qualified and supervisor-trained supervisor will supervise the therapists. Patients will be asked to give their consent for therapy sessions to be audio taped. These tapes will be used to allow the supervisor to monitor the quality of the therapy you receive. Taped material will not be used in the research study. If you prefer your sessions are not taped please state this when asked, choosing not to be taped would not prevent you from taking part.

What will I be asked to do?

You will be asked to fill in a questionnaire after each appointment. It will take 5-10 minutes to complete. All patients fill in questionnaires about their symptoms even if they do not take part in research. The patients who choose to take part will be asked extra questions about their experiences of the session. For example, you will be asked how helpful the session was for you. You and your therapist will be able to discuss your answers together to see how you are progressing. Your honesty is very important. If you felt a session was unhelpful your therapist will not be offended, in fact this may help them to understand what would be more helpful.

What if I don't get better?

Patients who don't get better will be offered ***the same care as any other patient***. For example, you may be offered a longer course of therapy, a different type of therapy, or be discharged back to your GP.

Why have I been invited to take part?

This study is particularly interested in the experiences of adults who are experiencing problems with low mood or depression.

When and where will the research take place?

We will ask you to complete the questionnaire immediately after your therapy appointment.

What other information will be collected?

As well as information about your symptoms, and your experiences of therapy we will also ask for some personal details, your age and gender for example.

How will the information you collect be used?

The information we collect will be used in two ways.

- By you and your therapist together to track your progress in therapy and monitor how you are feeling.
- By the researcher to try and find out which parts of the therapy were the most helpful. ***The answers from your questionnaires will be made anonymous before being used in the research.*** No one will know which set of answers came from which patient in the final research.

Will all of the information collected be confidential?

Yes. No names or identifying information will appear in any reports of the study.

Can I withdraw at any time?

Yes. You are free to choose not to take part in the study, or not to answer all the questions that are asked, and you can withdraw from the research at any time. Please note that if you withdraw from the study we can only remove the data if it has not been anonymised; if this has occurred we cannot identify the data and therefore cannot exclude it.

Will this effect my treatment?

No. Your withdrawal from the study will not effect the treatment you receive in any way. You will receive the same quality of care.

Who is doing this research?

Clair Stockton, a trainee clinical psychologist from the Clinical Psychology Unit at The University of Sheffield is leading the research. This research is an important part of the Doctor of Clinical Psychology qualification.

What if I wish to complain about the way in which this study has been conducted?

If you have a concern about any aspect of this study please contact the research supervisor, Dr Steve Kellett on 0114 222 6537 who will do his best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the University or NHS Complaints Procedure. The normal National Health Service complaints mechanisms are not compromised in any way because you have taken part in a research study.

University Complaints contact:
Dr David Fletcher,
Registrar and Secretary's Office,
University of Sheffield,
Firth Court, Western Bank,
Park, Carlton,
Sheffield, S10 2TN

NHS Complaints contact:
Beverley Davis, PCT Complaints Manager
Chief Executive
NHS Barnsley, Longfields Court
Middlewoods Way, Wharncliffe Business
Barnsley, S71 3GN
Telephone 01226 434175

Appendix x

Screening

Give IAPT questionnaires pre-screening

General Housekeeping:

- Confidentiality
- Identify depression status (DSM IV, SCID-1)
- Risk: Thoughts (freq/intensity), planning, intent (scaling), protective factors.
- What is CAT handout
- No. of sessions offered (8 therapy sessions, 1 follow up approx 8 wks later)
- Brief focussed work – permission to interrupt
- Clarify client & service contact details
- Time/dates of available appointments
- Arrangements for session cancellations (therapist and client)
- Missed/DNA session taken off total no. of sessions provided
- Plans for holidays
- Ask clients to discuss if therapy is not helpful rather than DNA/drop out
- Link above point to antibiotic metaphor (therapeutic dose/complete the course)
- Homework tasks important part of therapy
- Measures to complete at end of every session prior to leaving building
- Potential barriers to the above

Research housekeeping:

- Participant information sheet
- Taping sessions (state tapes will not form part of research data)
- Consent form

Homework tasks:

- Complete psychotherapy file
- Prep for session 1 – Priming for depression (We're going to talk about depression, how it affects you, how you are with people, how you are in yourself.)
- 5 words to describe yourself
- Explore barriers to homework completion/motivation to complete, confusion.

Session One - depression

Review homework task & any issues relating to psychotherapy file

Task analysis of recent depression event

Differences between activity when depressed versus not depressed (what do you stop doing? Things you enjoy doing?)

Model of self care:

- General coping style (e.g. head in sand, overworking, self criticism)
- How useful is this? How connected to the difficulties?
- What are you like with yourself when you're down?
- Opinions of self

Homework tasks:

Prime for personal/relationship history (growing up, major transitions, relationships with self and others)

- Draw a family tree
- Think about who you're most like and why
- Think about your relationships with siblings
- Draw a timeline of close relationships and provide brief descriptions of each
- Think of any patterns that exist in your close relationships
- What do you hope to get out of our work together
- Explore barriers to homework completion/motivation to complete, confusion.

Give Questionnaires

Session Two – personal/relational history

Allow approx 10 mins per area. Be active with answers, consider the event, coping and consequences e.g. how didmake you feel, how did you cope with...., do you still use these strategies? Are these strategies connected to your current difficulties?

- How would you describe (primary care giver)?
- Tell me about their personality (5 words to describe)
- Who are you most like and in what way?
- Have you any personal experience of physical/sexual/emotional abuse?
- Tell me what it was like for you growing up in your family
- Relationships with siblings
- Experiences of school
- What are you like in close relationships?
- How would partners describe you?
- What role do you play when relationships go wrong?

Give Questionnaires

Preparation for session one

Please complete the attached Psychotherapy File.

Next time we meet we're going to talk about your experience of depression. Think about the following questions and make some notes:

How does depression affect you?

How does depression affect how you are with other people?

How does depression affect your social, family and domestic life?

Write down five words to describe your personality.

Preparation for session two

Next time we meet we're going to talk about your experiences of growing up, your personal history and close relationships.

To prepare for this please draw a family tree below

Who are you most like and why?

What were your relationships with your brothers and sisters like (if you had them)?

Please draw a timeline of your close relationships and provide brief descriptions of each

Approximate dates/age

Brief description/key words



Can you see any patterns that exist in your close relationships?

What do you hope to get out of our work together

Appendix xi

Database search terms

Key search terms:

Therap* AND Letter*

Goodbye OR Farewell OR Ending AND Letter

Reformulation AND Letter

Therap* AND Writ*

Letter AND Writ*

Therap* AND Correspond*

Therap* AND Document*

Combined with:

Cognitive analytic therapy OR Cognitive behaviour therapy OR Narrative therapy OR

Counselling OR Psychotherapy OR Systemic therapy OR Psychoanalysis OR Family therapy

OR Solution focussed therapy OR Couples therapy OR Mental health OR Treatment

Appendix xii

Critical Skills Appraisal Tool; CASP (2006) (removed for copyright purposes)

Appendix xiii

Quality control checklist, Downs & Black (1998) (removed for copyright purposes)

Appendix xiv

Extended Data Table

Author/s	Main Focus	Methodology	Participants	Therapeutic Modality	Key Relevant Findings (Themes italicised)	No. of TLs	Position of TL in therapeutic intervention	Quality rating
Wagner, Weeks & L'Abate (1980)	TL as adjunct to intervention.	Controlled quantitative research.	n = 112 (56 couples).	Marital enrichment.	Linear letters improved therapeutic outcomes.	1 per case.	Session 4 of 6.	19/34
Evans & Parry (1996)	Short term impact of reformulation on presenting problem/s, alliance & helpfulness.	Multiple baseline case series. Quantitative & qualitative data.	n = 4 'Difficult to help' status.	Cognitive Analytic Therapy.	No impact on perceived helpfulness of sessions, therapeutic alliance or target problems. Clients reported considerable emotional impact.	1 per case.	Sessions 3-6 (case dependent).	14/32 (D&B) 15/34 (CASP)
Moules (2009)	Character & influence of TLs in Nursing.	Qualitative.	n = 4 (3 families). Physical health population.	Family Systems Nursing.	TLs influence is related to the tone of the individuals & therapeutic relationship. Summary of key elements of TL writing: Use of questions, commendations, markers of change, acknowledgement of suffering, conserve & protect memories.	11 in total.	Unspecified.	18/34
Freed et al (2010)	Influence of TL on therapeutic relationship & benefits to patients.	Qualitative.	n = 27 Elderly/disabled.	Psychiatric nursing (students).	4 Themes identified: <i>Feeling known & valued.</i> <i>Reciprocity.</i> <i>Motivating self-care.</i> <i>Tangible appreciation.</i>	1 per case.	Termination.	32/34
Howlett & Guthrie (2001)	Farewell letters in brief therapy.	Case series; qualitative.	n = 5 Patients with somatisation (not seeking therapy). Physical health population.	Psychodynamic-Interpersonal therapy	Farewell letters may enhance brief therapy by: Assisting patients in communicating self with others, continuing the work of therapy, managing end of therapy & acting as a transitional object. Potential for negative effects acknowledged.	1 per case.	Termination.	19/34

Extended Data Table

Author/s	Main Focus	Methodology	Participants	Therapeutic Modality	Key Relevant Findings (Themes italicised)	No. of TLs	Position of TL in therapeutic intervention	Quality rating
Pyle (2009)	TLs as relationally responsive practice.	Qualitative. (Thematic analysis of patient letters written to the researcher).	n = 7 'Serious mental health problems' or patients vulnerable to significant distress excluded.	Social work, psychology, counselling & Family Therapy.	2 Themes described: <i>Curiosity & connection</i> ; inquisitive & reciprocal nature of TLs. <i>Facilitating & hindering</i> ; ability of TL to invoke positive & negative affect/influence.	Unspecified. Minimum 1 per case.	Unspecified.	33/34
Shine & Westacott (2010)	Impact of reformulation on alliance & client perspective on change.	Case series. Quantitative & qualitative data.	n = 5 Diagnosed Axis I disorders.	Cognitive Analytic Therapy.	No impact on alliance. 7 themes: <i>Feeling heard. Understanding patterns Space to talk. Feeling accepted. Having something tangible. Working together. Feeling exposed.</i>	1 per case.	Sessions 4/5 (case dependent).	31/32 (D&B) 31/34 (CASP)
Hamill, Reid & Reynolds (2008)	Letters in Cognitive Analytic Therapy, the patient's experience.	Qualitative.	n = 8	Cognitive Analytic Therapy.	Overarching theme: <i>Making connections.</i> 4 sub-categories. <i>Connecting to: Self; Therapist; Therapeutic Process; &Others.</i>	Unspecified.	Unspecified.	33/34
Moules (2003)	TLs & the tone of the relationship.	Case study. Qualitative	n = 1 Physical health population.	Family Systems Nursing.	Suggests TLs are a powerful intervention & should reflect the tone, harmony and authenticity of the therapeutic relationship.	3	Letter 1: Termination of treatment phase. Letters 2 & 3: Following 2 further clinical sessions.	23/35
Moules (2002)	TLs in nursing practice.	Qualitative.	n = 2 (1 couple). Physical health population.	Family Systems Nursing.	Suggests TLS are influential & recommends authors acknowledge suffering, 'seduce' patients by offering questions, curiosity & commendations, & using tentative, speculative language.	4 in total.	1 after initial session. 1 at termination. 2 unspecified.	25/35

Extended Data Table

Author/s	Main Focus	Methodology	Participants	Therapeutic Modality	Key Relevant Findings (Themes italicised)	No. of TLs	Position of TL in therapeutic intervention	Quality rating
Vidgen & Williams (2001)	Clinicians letter writing practices in a child & family service.	Qualitative.	n = 6 Clinical Psychologists.	Clinical Psychology.	5 themes identified: <i>Typical practice; Use of clinical & micro skills; Addressing the relationship with the family; Messages to other professionals; Beliefs about the family.</i>	n/a	n/a	24/35
Rodgers (2009)	TLs challenge conventional therapeutic boundaries.	Qualitative.	n = 5	Psychology.	TLs challenge traditional constructions of therapeutic boundary & contribute to enhanced therapeutic intimacy via therapist availability, mutuality & vulnerability.	Unspecified.	Unspecified.	15/34
Smithbattle, Leander, Westhus, Freed & McLaughlin (2010)	TLs impact on clinician's relational skill development.	Qualitative.	n = 74 Undergraduate nursing students.	Psych-Mental Health Nursing & Public Health Nursing.	TLs promote clinical relational skills such as rapport building, increased reflective capacity & understanding patient perspectives.	2 per case.	Midway & termination.	31/34
Erlingsson (2009)	Clinicians writing TLs as an educational strategy.	Qualitative.	n = Unspecified. Undergraduate nursing students.	Family Nursing.	Students required support to focus on patient strengths/ resources & relinquish hierarchical roles. TL writing provided opportunities for reflection & theory-practice integration.	29 in total. Letters co-authored by 3 students.	Post assessment.	28/34
Pyle (2006)	TLs in Counselling practice. Client & Counsellor experiences.	Qualitative.	n = 9 (counsellors) n = 7 (Clients)	Various: Social work, psychology, counselling & Family Therapy.	4 Themes: <i>Consolidation: relationships & session content; In Perpetuity: the tangible & lasting presence of letters.</i> <i>Curiosity & connection; Facilitating & hindering</i> (Pyle 2009)	Unspecified. Minimum 1 per case.	Unspecified.	31/34

Extended Data Table

Author/s	Main Focus	Methodology	Participants	Therapeutic Modality	Key Relevant Findings (Themes italicised)	No. of TLs	Position of TL in therapeutic intervention	Quality rating
Kellett (2007)	Evaluation of CAT intervention for Histrionic Personality Disorder	Single Case Experimental Design.	n = 1	Cognitive Analytic Therapy.	Negative impact of termination despite incremental improvements in target problems during therapy. No evidence of immediate effects arising from TL interventions.	2	At sessions 4 & 24 (24 session contract + 4 follow up appointments).	16/32
Kellett (2005)	Evidence of sudden gains when treating Dissociative Identity Disorder.	Single Case Experimental Design.	n = 1	Cognitive Analytic Therapy.	Sudden gains observed following reformulation & associated TL intervention (reduction in target problem - dissociative symptomology).	2	At sessions 4 & 24 (24 session contract + 4 follow up appointments).	17/32
Kellett (2012)	CAT intervention for Paranoid Personality Disorder.	Hermeneutic Single Case Experimental Design.	n = 1	Cognitive Analytic Therapy.	Sudden gains observed following reformulation & associated TL intervention (reduction in target problem - suspiciousness).	2	At sessions 4 & 24 (24 session contract + 4 follow up appointments).	18/32
Rayner, Thompson & Walsh (2011)	Clients experience of reformulation in Cognitive Analytic Therapy	Qualitative	n = 9	Cognitive Analytic Therapy.	Overarching theme of ' <i>doing with</i> ' the therapist. 4 sub-themes of : <i>Being with the therapist; Keeping it real; understanding & feeling; CAT tools.</i>	Unspecified	Unspecified	29/34

Appendix xv

Qualitative Themes, contributory facets

Contributory facets in categorical representation of literature

Category	Facet	Reference
Making Connections	Feeling known and valued; Reciprocity	Freed et al (2010)
	Curiosity and connection; Solidification (relationships)	Pyle (2006, 2009)
	Connecting to self, therapy, therapist and others	Hamill, Reid & Reynolds (2010)
Extending the Work of Therapy	Motivating self care	Freed et al (2010)
	Farewell letters act as a secure base and transitional object, aiding assimilation	Howlett & Guthrie (2001)
	Aide mémoire	Pyle (2006, 2009); Moules (2002, 2009)
	Solidification and consolidation of session content	Pyle (2009)
Managing Endings	TL as tangible transitional object	Howlett & Guthrie (2001); Moules (2002, 2009)
	TL provides tangible appreciation	Freed et al (2010)
	TL as precious object	Moules (2002, 2009)
	TL in perpetuity, lasting and tangible object	Pyle (2006, 2009)

Negative Impacts	Hindering effects; TLs arouse and maintain negative affective states	Pyle (2006)
	TLs invoke distressing memories and maintain persecutory eye of therapist	Howlett & Guthrie (2001)
Therapeutic Outcomes	Short-term impact of reformulation in CAT	Evans & Parry (1996); Shine & Westacott (2010)
	Case specific insights and evidence of sudden gains.	Kellett (2005, 2007, 2012)
	Linear TLs enhance client outcomes	Wagner, Weeks & L'Abate (1980)

Diagrammatic representation of themes Hamill, Reid & Reynolds (2008) (removed for copyright purposes)